A MINDFULNESS-BASED COGNITIVE PSYCHOEDUCATIONAL GROUP MANUAL FOR PROBLEM GAMBLING

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Abstract

This project provides a comprehensive overview of the research literature on problem gambling in adults and includes a detailed mindfulness-based psychoeducational group manual for problem gambling, complete with an extensive group counselling consent form, assessment and screening protocols, 10 user-friendly lesson plans, templates for a marketing poster and session notes, ample client handouts, and facilitator notes. The literature review commences with the definition of problem gambling and continues with a discussion regarding the maintenance, prevalence, psychosocial costs, and consequences of problem gambling. The literature review concludes highlighting the definition of mindfulness, its effectiveness, the relevance and effectiveness of mindfulness-based therapy for problem gambling, and the effectiveness of group therapy for problem gambling. The project devotes substantial consideration to the treatment of problem gambling using mindfulness-based cognitive therapy. One of the strengths of this project is it addressed the lack of resources in rural areas for problem gamblers. The group program manual, entitled Freedom from the Gambling Fog, is designed to be used by counsellors who do not have the time or skill set to research or design a comprehensive group treatment plan.

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Chapter One: Introduction

This project includes five chapters and an appendix. Chapter 1 highlights the intent of the project, the rationale and importance of the topic, and the structure of the project.

The Intent of the Project

The intent of this Master of Counselling project is to provide an applied resource for counsellors, which includes mindfulness-related treatment options when working with adult clients who indicate a desire to overcome their problematic gambling behaviours. Specifically, I developed a psychoeducational group (PEG) manual, complete with pre- and postscreening options, to treat pathological gambling integrating mindfulness-based cognitive therapy within a coed adult group counselling setting.

The Rationale and Importance of the Topic

I designed a group program for my Master of Counselling project because in the rural areas that I work in as a counsellor (North Eastern Alberta) there are limited resources for people with pathological gambling; therefore, a PEG manual on this topic could be useful for counsellors. Additionally, there are no gambling anonymous meetings in the town that I work in, and the closest gambling anonymous meeting is a half an hour away, but I have heard from various clients that it is not well attended. Encouraging counsellors to offer PEG groups is a worthwhile pursuit, which may be made easier if counsellors have access to a comprehensive, well-designed group manual on treating pathological gambling using a mindfulness-based cognitive therapy program.

Project Structure

Chapter 2 of this project provides a review of the literature on gambling addiction. Chapter 3 discusses the literature relevant to the treatment of gambling addiction, specifically mindfulness-based cognitive therapy and group therapy for gambling addiction. The methodology is presented in Chapter 4. The final chapter notes the strengths and limitations of the group manual. Appendix A through Y of the project contains a comprehensive group program manual, which includes a preamble, its own table of contents, as well as lesson plans and facilitator notes.

In sum, since treatment resources for people with problem gambling are limited, counsellors can offer a PEG by following this mindfulness-based group manual, which may meet the needs of clients with gambling problems. The following chapter, Chapter 2, provides background information regarding the current literature pertaining to gambling addiction.

Chapter Two: Gambling Addiction

This chapter presents the current academic literature related to gambling addiction in adults. In this chapter, I discuss the current definition of gambling addiction, why people gamble problematically, gambling addiction and mental health, prevalence, psychosocial costs of gambling addiction, and the consequences of gambling addiction. It is important to note that this project will not be focused on gambling issues but on treatment issues of this common presenting problem.

Definition of Gambling Addiction

Gambling is an activity that includes gambling tickets (lottery, daily lottery, instant-win, raffles), bingo, gambling with family or friends (cards, board games), electronic gambling (VLTs, casino or racetrack gaming terminals, internet), sports betting (sport select, sports pools, sporting events, bookmaker), horse racing, casinos (poker, craps, roulette, blackjack), speculative investments (stocks, options, commodities),and other gambling (games of skill, unregulated card rooms, any other). Most individuals gamble as a form of entertainment, but some may develop problematic issues associated with the consequences of gambling.

There are several terms used to describe gambling issues, such as gambling addiction, pathological gambling, problem gambling, and so on, but for the purpose of this project these terms will be used interchangeably. Shaffer, Hall, and Vanderbilt (1999) distinguished between problem gambling and pathological gambling; pathological gamblers are those who meet the established diagnostic criteria for gambling, while problem gamblers may experience some problems, but fail to meet the diagnostic criteria. The *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric

Association, 2000) categorized pathological gambling as an impulse-control disorder with the main feature being "persistent and recurrent maladaptive gambling behaviour" (p. 671), which is not otherwise accounted for by a manic episode. People who gamble pathologically present as being preoccupied with thoughts of gambling, develop a tolerance to gambling (i.e., need to gamble with more money in order to reach the same level of excitement), experience lack of control to cut back or abstain from gambling, experience restlessness or irritability when trying to cut down or abstain from gambling, chase gambling losses, may be dishonest with people in their lives to hide gambling behaviour, may commit illegal acts (i.e., stealing) to finance gambling, experience negative consequences in major life areas (i.e., employment, relationships, education, mental health, etc.) as a result of gambling, and lastly, may rely on others to solve financial trouble caused by gambling (American Psychiatric Association, 2000).

Consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) diagnostic criteria, Smith and Wynne (2002) investigated measures of problem gambling using the nine-item Problem Gambling Severity Index with Albertans and found that the following behaviour distinguishes problem from nonproblem gambling:

> Betting more than one can afford to lose; exceeding pre-set time and spending limits; increasing betting levels to maintain the same degree of excitement; returning quickly to win back losses; borrowing or selling property to pay gambling debts or to obtain money to gamble; lying and hiding evidence of gambling activity; and committing illegal acts such as stealing to get money to gamble. (p. 45)

Apparently, one dimension that specifically distinguishes problem gamblers from nonproblem gamblers is that problem gamblers are more likely to recognize that they have an issue with gambling. For instance, Smith and Wynne (2002) found that none of nonproblem gamblers believed they might have a gambling problem "most of the time" or "almost always" whereas 43.4% of problem gamblers indicated awareness they did have a problem most or almost always of the time. It appears the majority of problem gamblers suspect that they have a gambling problem when they experience negative consequences as a result of gambling (Smith & Wynne, 2002).

In addition to the Problem Gambling Severity Index, other tools that are widely used to categorize problem gambling include the Canadian Problem Gambling Index (Wynne, 2002) and the South Oakes Gambling Screen. Lesieur and Blume (1987) developed the South Oakes Gambling Screen, which is not as theory based as the Canadian Problem Gambling Index (Smith & Wynne, 2002), and is based on the criteria for pathological gambling from an older version of the diagnostic manual (Lesieur & Blume, 1987). The Canadian Problem Gambling Index is normed on Canadian populations, and it is better able to distinguish between problem gambler types (Smith & Wynne, 2002).

Assessment measures are used to determine the extent and severity of problem gambling. Ample research has shown the negative consequences of problematic gambling. However, despite these consequences people continue to engage in this behaviour. The next section highlights the prevalence of gambling addiction.

Prevalence

This section will address problem gambling prevalence rates related to various characteristics, such as video lottery terminals (VLTs), Alberta, youth, substance use, gender, and culture.

Video lottery terminals. In Canada, VLTs are the most played games (Wiebe & Cox, 2001), which are hypothesized to be due to their addictive features and their availability in the community (i.e., VLTs are located in lounges and local restaurants). One major limitation of the latter data is that the data were collected from a clinical urban sample, but as previously mentioned, most people with gambling problems do not seek treatment; therefore, a clinical urban sample may not be representative of a community sample with problem gambling and those from rural areas (Wiebe & Cox, 2001).

Alberta. Compared to residents in other Canadian provinces, residents in Northern Alberta are at an increased risk or are currently experiencing higher rates of problematic gambling. More specifically, only 1.3% of adult Albertans experience problem gambling, but a staggering 15% of adult Albertans are at risk of developing problematic gambling (Smith & Wynne, 2002).

Youth. Furthermore, Huang and Boyer (2007) indicated, among Canadian youth aged 15 to 24 years, 61.35% gambled in the past 12 months and the national prevalence of moderate-risk or problematic gambling was 2.22% (i.e., 3.30% of males and 1.10% of females). Males have significantly higher prevalence of problematic gambling than females. Regional prevalence rates of youth moderate-risk or problem gambling are 1.37% in British Columbia, 2.17% in the Prairie Provinces, 2.75% in Ontario, 2.12% in

Quebec, and 1.71% in the Atlantic Provinces (Huang & Boyer, 2007). The major implications of the latter statistics are that,

> Canadians youth aged 15 to 24 years are at greater risk for gambling problems than adults aged 25 years or older; young men consistently have higher prevalence of gambling problems than young women in Canada; and there is interregional variability in the prevalence of youth gambling problems in Canada. (Huang & Boyer, 2007, p. 657)

Problem gambling among youth in Canada, especially in the prairie provinces, appears to be on the rise since the emergence of VLTs (Huang & Boyer, 2007).

Substance use. In Canada, according to Wiebe and Cox (2001), gamblers may also smoke and use alcohol. These authors found that 70% of people seeking treatment for problem gambling also reported being cigarette smokers. Further, their sample (n = 1376) revealed only one quarter of gamblers reported abusing alcohol. This percentage is inconsistent with the findings that suggest that people with gambling addiction have a high likelihood of having an alcohol addiction (Brooker, Clara, & Cox, 2009).

People seeking treatment for gambling problems appear to be higher-functioning, are well educated, and have high incomes and socioeconomic status compared to people seeking treatment for alcohol addiction (Wiebe & Cox, 2001). Thus, it appears that those with gambling problems are uncharacteristic of the adults who usually seek substance abuse treatment (Wiebe & Cox, 2001). Many of the individuals with problem gambling would not seek out addictions treatment if not for his/her gambling issues (Wiebe & Cox, 2001).

Gender. There is also a high proportion of women (almost 40%) in the Canadian gambling sample compared to the United States, but more men than women have gambling problems (Wiebe & Cox, 2001).

Culture. Furthermore, Aboriginal gamblers compared to gamblers from other ethnic backgrounds are significantly more at risk for developing gambling problems (Smith & Wynne, 2002). It is important to mention that the sample size in the latter study was small (n=33); therefore, further research is needed for confirmation (Smith & Wynne, 2002). Specific Aboriginal groups were not identified in the latter study. Additionally, the reason why problem gambling prevalence rates may be higher among Aboriginals in Alberta compared to other ethnic backgrounds is currently unknown. Future research should examine gambling issues among Aboriginals to provide context to the prevalence rates (i.e., is there any connection between problem gambling among First Nations people and rural communities, casinos on First Nations land, and socialization issues?).

This section addressed problem gambling prevalence rates related to several factors, such as video lottery terminals (VLTs), Alberta, youth, substance use, gender, and culture. The next section examines why people gamble problematically.

Why Do People Gamble Problematically?

The literature documents several reasons why people develop problem gambling. First, Smith and Wynne (2002) investigated problem gambling correlates and found that if a gambler had a family member with a gambling or substance abuse problem that increased his/her risk of problem gambling. Two explanations for the latter finding is that perhaps people are genetically predisposed to gambling addiction and/or have

developed problem gambling as a learned maladaptive coping behaviour. This latter hypothesis will be explored next by examining the psychosocial payoffs of gambling.

Psychosocial variables. People may gamble pathologically to escape from distressing situations in their lives. Wood and Griffiths's (2007) qualitative investigation of pathological gamblers found the use of escape-based coping as a prominent stress-management strategy. Escape-based coping was achieved by these individuals gambling to modify mood, to fantasize, to dissociate and/or change arousal level, to fill a void, and/or to avoid problems. As previously noted, pathological gambling behaviour leads to negative consequences and those negative consequences may be escaped through more gambling. People who gamble pathologically tend to believe that they have control over gambling outcome and they may chase their gambling losses, which is also a form of escaping negative consequences, including mood states (Wood & Griffiths, 2007).

There is substantial evidence in the research literature to suggest that motivational factors relating to feelings of dissociation, control, excitement, and relaxation may also keep people gambling (e.g., Crawford & Frances, 2004; Diskin & Hodgins, 1999; Ledgerwood & Petry, 2006; Raylu & Oei, 2002). There is also an extensive body of research indicating that informational biases or faulty beliefs are related to the development and maintenance of problem gambling (Delfabbro & Winefield, 2000; Doiron & Nicki, 2007; Ladouceur, Boisvert, & Dumont, 1994; Toneatto & Sobell, 1990). Specifically, faulty cognitions related to gambling behavior is related to the increased risk for problem gambling (Smith & Wynne, 2002). More specifically, the belief that one can influence, control or predict the outcome of a chance event is directly related to the

maintenance of gambling behavior and addiction (Jacobsen, Knudsen, Krogh, Pallesen, & Molde, 2007).

Learning theory. Another explanation for why people develop problem gambling is based on learning theory, specifically reinforcement schedules. For instance, Smith and Wynne (2002) found that a gambler is more at risk of problem gambling if they experience an early big win or loss, which reinforces the player to play again. Learning theories suggest that winnings are considered as positive reinforcements for gambling behavior, and random and uncertain pay outs can lead to maintenance of gambling behavior (Skinner, 1953).

In addition, the attractiveness of certain gambling activities can be stimulating and rewarding for some people. For instance, Griffiths (1993) noted two aspects of VLT games that contribute to its addictiveness are situational characteristics of VLTs (i.e., availability and accessibility) and structural characteristics of VLTs (i.e., speed of play, payout intervals, game choices, and audio and visual stimuli). Burns (2005) highlighted that there are two different varieties of VLT games in the Canadian marketplace: winning-focused games, such as Enchanted Unicorn, and entertainment-focused games, such as Royal Spins (Nicki, Gallagher, & Cormier, 2007). Nicki et al. (2007) investigated attractiveness of VLT play for problem and nonproblem gamblers in New Brunswick. Nicki et al. found that a winning-focused game compared to the entertainment-focused variety is associated with dissociation and arousal for problem gamblers, but not for nonproblem gamblers.

Winning-focused games also seem to foster strong faulty gambling beliefs among problem gamblers, such as the illusion of control, illusion of correlation, calculation of

probability, superstitious beliefs, perception of a near miss (Jacobsen et al., 2007), among others. Nicki et al. (2007) suggested that the gambling industry should examine the nature of VLT games introduced into the marketplace and possibly develop games that are more entertainment-focused rather than winning-focused since entertainment-focused games do not hold the same addictive potential as winning-focused games (Nicki et al., 2007).

Technology. In addition to game characteristics, technology advances may be related to problem gambling. For instance, the rise of technology may have influenced the emergence of Internet gambling because salient factors (i.e., accessibility, affordability, anonymity, convenience, escape immersion or dissociation, disinhibition, event frequency, asociability, interactivity, and simulation) may influence the addictive potential of gambling online (Griffiths, 2003). This does not mean that everyone is susceptible to developing gambling addictions, but what this means is that at a societal versus individual level, more problems are hypothesized because of the above mentioned factors (Griffiths, 2003).

This section addressed why people gamble. It appears there are various factors involved in explaining gambling addiction, such as context-specific variables and individual factors. The next section will examine the psychosocial costs of gambling addiction.

Psychosocial Costs of Gambling Addiction

The problems caused by gambling can negatively impact various life areas, such as personal health (emotional and physical), relationships, finances, legal, and occupation (Walker et al., 2006). For example, problem gambling is significantly related to worse

self-rated health (Hong, Sacco, & Cunningham-Williams, 2009). This finding supported the work by Desai, Desai, and Potenza (2007), who found poorer health in those with problem and recreational gambling experiences.

In addition to poor health, gambling addiction can add additional stress to the person's relationships. Ferland et al. (2008) found that both the person with the gambling addiction and their spouse encounter several negative consequences such as social life (i.e., conflict with relatives, isolation, and lack of funds may impact the ability to go out), lowered psychological wellbeing (i.e., stress, depression, feelings of guilt, and suicidal ideation), problems at work, and financial troubles (the most negatively impacted). It appears as though spouses rate the intensity of the negative consequences arising from the gambling addiction as more problematic than the person with the gambling problem, except for psychological distress, which the person with the gambling problem rates as more intense than their spouse's rating (Ferland et al., 2008).

In addition, Smith and Wynne (2002) examined personal and social consequences of problem gambling in a study with more than 1,000 participants. In regards to personal consequences, Smith and Wynne found that people with problem gambling are significantly more likely compared to other gambler subtypes to have health issues such as stress and anxiety (17.3%), sleeping problems (13%), and feelings of irritability and restlessness as a result of gambling (26.1%).

Additionally, Smith and Wynne (2002) found that people with problem gambling are significantly more likely compared to other gambler subtypes to indicate that others

have criticized their gambling (17.3%) and note feeling guilty regarding their gambling behaviour (60.9%). In regards to the social consequences, Smith and Wynne found people with problem gambling are significantly more likely than the other gambler subtypes to experience negative financial strain impacting themselves or family members (17.3%), and relational issues with family or friends (13%).

The psychosocial costs to engaging in problematic gambling seem significant. This is important information for counsellors to be aware of because counsellors will need to conduct comprehensive intakes examining how gambling has impacted the client's life. The next section discusses the connection between gambling addiction and mental health.

Gambling Addiction and Mental Health

In Canada, there is a higher prevalence of problem gambling in populations that have mood disorders, such as bipolar disorder and major depressive disorder, as compared with community populations (Kennedy et al., 2010). Additionally, there is high comorbidity of substance use and anxiety disorders among persons who have both problem gambling and mood disorder (Kennedy et al., 2010), which suggests that an assessment for comorbidity and relevant dual treatment should be offered.

The interplay between mental illness and gambling might appear to be related to a reduced quality of life. For example, people with depression may engage in gambling in an attempt to enhance their mood (Kennedy et al., 2010). In contrast, decreased quality of life and negative consequences of gambling may cause some people with problem gambling to become depressed, and mood affects motivation to gamble (Kennedy et al., 2010). When someone is in a manic state, pleasure-seeking and risk-taking, such as

gambling behaviour, may occur and there is usually limited processing of what negative consequences may arise as a result (Kennedy et al., 2010).

Additionally, Brooker et al. (2009) investigated the severity of gambling behaviour in the Canadian general population, which is consistent with the aforementioned findings of Kennedy et al. (2010). Brooker et al. revealed a significant positive correlation between problem gambling and various mental health behaviours and disorders, with the strongest association being for suicide attempts. In addition to suicide attempts, Brooker et al. found that problem gambling was associated with suicide ideation, mania, social phobia, major depression, and alcohol interference. Unfortunately, the work of Seguin et al. (2010) found that suicidal people with problem gambling are less likely to contact mental health services compared to people without problem gambling who are suicidal. Lower service utilization related with suicides among people with problem gambling justifies bettering assessment and "engagement in care and treatment with respect to problem gambling, especially when comorbidity is present" (Seguin et al., 2010, p. 541).

Seguin et al. (2010) found that psychopathology is prevalent in both people with depression and problem gambling, but problem gamblers are twice as likely to have a cluster B personality disorder diagnosis (i.e., antisocial, borderline, histrionic, and narcissistic). In addition, gambling can be categorized according to distinguishable personality structures (Vachon & Bagby, 2009). The three problem gambling subtypes include the simple cluster, hedonic cluster, and the demoralized cluster (Vachon & Bagby, 2009). First, the simple cluster is characterized by low psychopathology comorbidity and normative trait scores (Vachon & Bagby, 2009). Second, the hedonic

cluster is characterized by moderate psychopathology comorbidity and a tendency for pleasure seeking and positive affect (Vachon & Bagby, 2009). Third, the demoralized cluster is characterized by high psychopathology comorbidity and a tendency to have negative affect, low positive emotionality, and disinhibition. The latter clusters suggest that problem gambling may have differing etiologies (Vachon & Bagby, 2009).

Overall this section demonstrated that mental illness and gambling may occur concurrently, which is important for counsellors to consider regarding diagnosis and treatment. The final section addresses a controversial area of how the government may profit from those with gambling addictions, which has implications for treatment.

Government-Sponsored Gambling

According to Marshall (2010), revenue generated from gambling (i.e., government-run lotteries, VLTs, casinos and slot machines not in casinos) brought in $2,205 million dollars in Alberta with a net revenue of $2.73 billion in 1992, which rose to $13.75 billion in 2009. Williams and Wood (2004) indicated the following:

> The legitimacy of government-sponsored gambling and its continued expansion depends in part on the impact that gambling has on society and the extent to which gambling revenue is derived from vulnerable individuals. . . . Using recent secondary data collected in eight Canadian provinces, we estimate this proportion to be 23.1%, compared to a problem gambling prevalence rate of 4.2%. This estimate must be seen as tentative, however, as self-reported expenditures are 2.1 times higher than actual provincial gaming revenues. (p. 33)

Williams and Woods (2004) findings suggest that a large percentage of the gambling revenue is generated from people who gamble problematically (i.e., 23.1%), which puts

into question what is being done to protect those vulnerable persons. One way that the Alberta Gaming and Liquor Corporation (2009) has attempted to aid those most vulnerable is to allocate some of the generated gambling revenue toward problem-gambling prevention, promotion of responsible gaming, research, and to the treatment of problem gambling.

Considering the psychosocial costs and societal consequences of problem gambling (Smith & Wynne, 2002), it makes sense to utilize government or gambling revenue funds to assist those with problematic gambling. For example, perhaps proposed groups like the one introduced in this project would be a program the government would be willing to sponsor in an attempt to provide additional treatment options for individuals with problem gambling.

In summary, this chapter provided the necessary framework for the proposed group manual. A definition of gambling addiction was provided, as well as a discussion of the prevalence of gambling addiction, why people gamble problematically, the psychosocial costs of gambling addiction, the connection between gambling addiction and mental health, and the need for the government to help those with gambling issues reduce their addiction to this activity. The next chapter, to support the proposed group program to offer help to those that no longer want to gamble, will examine various treatment options for problem gamblers, specifically mindfulness-based cognitive therapy.

Chapter Three: Treatment of Gambling Issues

This chapter highlights topics related to the treatment of gambling addiction as it relates to the proposed group program (Appendix A). More specifically, this chapter discuses mindfulness-based cognitive therapy (MBCT), the effectiveness mindfulness, the relevance of mindfulness as a treatment strategy for gambling addiction, and the effectiveness of MBCT for the treatment of gambling addiction. Given the proposed treatment is within a group setting, a brief review of the group counselling best practices, and the effectiveness of group counselling for the treatment of gambling addiction will be presented.

What is Mindfulness-Based Cognitive Therapy?

The concept of mindfulness originates from Eastern traditions and involves practicing a single-minded type of attention. The practice of mindfulness has been incorporated within Western therapeutic practice over the years (Didonna, 2009). Many studies have suggested the benefits of combining the concept of mindfulness and Western counselling frameworks, such as cognitive therapy (Dryden & Still, 2006; Kabat-Zinn, 2003; Walsh & Shapiro, 2006). Cognitive therapy involves helping people change how they feel and act by reconstructing unhealthy beliefs. Cognitive therapy approaches are present focused and do not require clients to go into the past for answers (Corey, 2009), which is consistent with the present-moment awareness characteristic of mindfulness. When theoretical approaches integrate mindfulness, counsellors are said to be using mindfulness-integrated interventions.

Counsellors who employ mindfulness into their treatment, teach clients to focus on openness, acceptance, and curiosity versus avoidance of experience (Didonna, 2009).

A mindful practice teaches clients to acknowledge the reality of their thoughts, feelings, behaviours, and environment, which can diminish and eventually eliminate what the client previously thought of as an automatic physiological or psychological response. Clients' homework often involves utilizing this state of mindfulness in various situations to extend the use of this skill outside of therapy (Lau & McMain, 2005).

Effectiveness of Mindfulness

Mindfulness practice has been shown to enhance emotion regulation, decrease reactivity, increase response flexibility, and benefit intrapersonal and interpersonal relationships for various groups of people (Davis & Hayes, 2011). Additionally, mental health and health care providers may benefit from mindfulness training in the counselling context; it has been proposed that counsellors who engage in mindfulness activities or who possess higher states of mindfulness have better treatment outcomes than those who do not practice mindfulness with their clients (Escuriex & Labbé, 2011).

Mindfulness has been used as a treatment approach for various issues. For instance, one meta-analysis demonstrated that mindfulness-based therapy has promising benefits for treating anxiety and mood problems in clinical populations (Hofmann, Sawyer, Witt, & Oh, 2010). Studies have suggested mindfulness-based programs to treat various issues, such as other psychopathologies like depression, obsessive compulsive disorder, attention deficit hyperactivity disorder, addictions, among other pathologies. Mindfulness approaches have been recommended for use for other nonpathological concerns as well, such as chronic pain and stress (Didonna, 2009), and has even been successfully used in schools with children and hospitals with patients (Mindfulness Institute, n.d.). Overall, it seems mindfulness-based programs provide promising help to

improve the wellbeing of clients and patients, despite some limitations which will be addressed next.

Overall, there are several factors to keep in mind regarding the use of MBCT with clients. First, it is important to assess clients' motivational level for change, which may vary from client to client, so that interventions can be tailored to what the client can handle. Some clients may lack motivation to try new strategies, especially if self-efficacy is low. If clients lack confidence to engage in MBCT, then they may not engage in the intervention. Modifying the program may be needed if the latter case arises. For instance, instead of doing meditation for 15 minutes daily, perhaps reducing it to 5 minutes every second day would be more manageable for some clients, in essence increasing their self-efficacy. If goals are unrealistic, they are prone to failure and reinforce negative self-schema, hence perpetuating the issue. Secondly, mindfulness interventions can be a significant time commitment, since it involves weekly sessions for eight weeks, possibly involving significant travel time, and many assigned homework exercises. This substantial time requirement may be inconvenient for clients (Kocovski, Segal, & Battista, 2009).

An additional consideration when using mindfulness-based strategies is to warn clients of the common hindrances to being mindful. Common challenges when practicing mindfulness exercises are desire—wanting things to be different right away, aversion—resisting the experience of the present moment, sleepiness—resistance to painful thoughts or emotions, restlessness—a distracting flood of thoughts and emotions, and doubt—feelings of fear and hopelessness (McKay, Wood, & Brantley, 2007).

Another limitation of meditative interventions is that adverse effects have been found with transcendental meditation and longer-term meditation retreats, as these can increase depressive and anxious symptoms (Kocovski et al., 2009). MBCT is a short intervention and is not classified as transcendental meditation; the likelihood that MBCT is associated with increased anxiety and depression is low. Sheppard and Teasdale (2004) indicated that people recovering from depression show an increase in metacognitive monitoring of dysfunctional schemas rather than a reduction in dysfunctional schema; therefore, being aware of dysfunctional thoughts versus denying thoughts is related to improved mood. Greeson and Brantley (2009) suggested that mindfulness-based programs have produced clinically significant reductions in anxiety, mood disturbance, and stress-related physical symptoms. To ensure that MBCT is working for clients, practitioners can monitor clients' anxiety levels through the use of assessment tools.

Another critical issue with meditative exercises is that some may view the word "meditation" as fraudulent mysticism. Meditation was once demonized and considered mysterious. Eastern views can be explained using universal language, so that clients who are "suffering can understand why meditation might be helpful to them without all the cultural and ideological baggage that invariably accompanies the whole Eastern gestalt, and for that matter, spirituality as it is often spoken about" (Didonna, 2009, p. 5). Since some clients may have predetermined views of what mindfulness involves and may critique it as an inapt tactic, explaining what mindfulness entails and how it is an appropriate method may clear up any misunderstandings (Kocovski et al., 2009).

Another struggle that clients may have with MBCT is that it requires them to reduce avoidance of emotionally charged situations, which may not be an easy thing to do. Clients' attempts to avoid the inner experience of emotions fail to address the root cause of emotional distress and avoidant coping actually reinforces intense reactions to reoccur inappropriately. Present moment lack of awareness or attention can lead to cognitive intrusions that may be inaccurate and distressing. The goal of MBCT is to increase clients' awareness in order to minimize inaccurate cognitive intrusions (Greeson & Brantley, 2009). Increasing clients' tolerance to uncomfortable circumstances by bringing their attention to it rather than avoiding it helps to reduce distress (Wells, 2005). Convincing clients to go against what seems natural, which is to avoid what is uncomfortable, may pose as a challenge.

Furthermore, MBCT may not match the client's style of learning. Clients need to consent to suggested interventions, and if they do not like the idea of it, they can refuse to engage in the intervention. Since mindfulness is an Eastern philosophy, clients may not accept that philosophy, especially if it goes against their own philosophical beliefs. Counsellors need to be culturally sensitive to clients' views; therefore, they may need to modify their approach to match clients' needs. Counsellors need to assess if MBCT is a good fit for individuals and for the presenting problem, as the change process will be more effective if clients adopt it. The change process is complex and not as straight forward as it may appear to be. Another cited limitation is that the benefits of mindfulness cease to be very effective if practice is ceased (Walsh & Shapiro, 2006); therefore, ensuring that clients maintain consistency with MBCT after therapy is important. One solution is to have periodic follow-up appointments to reinforce

adherence. The next section will address the relevance of mindfulness as a treatment strategy for gambling addiction.

Relevance of Mindfulness as a Treatment Strategy for Gambling Addiction

Mindfulness as a treatment strategy for gambling addiction appears to be relevant. Peters, Erisman, Upton, Baer, and Roemer (2011) reported that mindfulness appeared to be strongly negatively correlated with impulsivity, meaning as mindfulness increases, impulsivity decreases. More specifically, mindfulness is partly characterized by an increased awareness of ongoing activity, which may promote better regulation of behaviour even when negative affect or distress is present. This is important in the reduction of gambling because since addiction is related to the avoidance of experience, increasing awareness of experience makes sense as the goal of treatment (Bien, 2009).

Nonjudgement is another aspect of mindfulness that may also lead to reduced negative urgency and increased perseverance (Peters et al., 2011). Thus, a person with gambling issues might evoke mindfulness to practice acceptance of one's inner experience as opposed to judging their thoughts and emotions as good or bad (Peters et al., 2011). Furthermore, the nonreactivity component of mindfulness may be involved in reduced negative urgency and increased premeditation. The latter finding appears to be a good explanation of how treatments that include training in mindfulness skills create change in individuals with impulse control disorders (Peters et al., 2011). As previously mentioned, problem gambling is considered an impulse control disorder; therefore, based on the latter information, it seems plausible that mindfulness interventions would be an effective treatment strategy for problem gambling.

Effectiveness of Mindfulness-Based Cognitive Therapy for Treating Gambling Addiction

There are no known documented MBCT group approaches utilized to specifically treat problematic gambling addiction; therefore this project contributes to the literature. What is known about approaches similar to MBCT will be discussed.

First, Lindberg, Fernie, and Spada (2011) investigated metacognitions among 91 problem gamblers and found a significant positive correlation between anxiety, depression, and metacognitions. Hierarchical regression analyses showed that "two metacognitive constructs (negative beliefs about thoughts concerning uncontrollability and danger and beliefs about the need to control thoughts) predicted gambling behaviour independently of anxiety and depression" (Lindberg et al., 2011, p. 73). The implication of this finding is that metacognitive-type therapies, like mindfulness, may prove beneficial for the treatment of gambling addiction because gamblers will learn to be flexible and find alternative ways of relating to mental events instead of resorting to gambling as a way of controlling their mental state (Lindberg et al., 2011).

However, mindfulness alone may not prove to be enough to treat severe mental health problems involving disordered emotion regulation because the literature indicated that mindfulness is most useful when it is combined with cognitive behavioural therapy (Lindberg et al., 2011). Thus, mindfulness meditation may have utility when coupled with cognitive behavioural therapy (CBT) for the treatment of gambling addiction because the magnitude of maladaptive thinking among problem gamblers is a challenge to reconstruct, so mindfulness meditation is promising as an adjunctive intervention in

assisting problem gamblers to cope with gambling-related distorted beliefs (Toneatto, Vettese, & Nguyen, 2007).

This assumption was supported by a study that examined and found that mindfulness-based stress reduction has been found to be a successful addiction relapse prevention intervention for people in early recovery from addiction as determined by Vallejo and Amaro (2009) who investigated the qualitative effectiveness of a mindfulness-based stress reduction program (MBSR) with 161 women in community-based addiction treatment setting. They commented on the process of implementation and adaptation of MBSR, and shared lessons learned regarding acceptability, fit, and feasibility of the program. Suggestions included helping clients view the program as relevant to their recovery and helping them to apply their learning to everyday life, explain thoroughly the connection of stress to craving and relapse, and relating key aspects of MBSR to relapse prevention, such triggers for cravings and relapse, and adaptation of the program to meet the needs of clients related to literacy issues, attentions spans, and trauma histories (Vallejo & Amaro, 2009). Also, the addiction clients rated mindfulness-based stress reduction highly in terms of acceptability and satisfaction as evidenced by participant satisfaction surveys (Vallejo & Amaro, 2009).

Furthermore, gambling addiction can significantly improve with CBT. For instance, Sylvain, Ladouceur, and Boisvert (1997) investigated the effectiveness of CBT and found that 86% of the treated participants (n = 29) were no longer considered pathological gamblers (according to standard assessment tools) at the end of 6- and 12-month follow-ups. Participants also “had a greater perception of control of their

gambling problem as well as an increased self-efficacy in high-risk gambling situations" (Sylvain et al., 1997, p. 731) after CBT treatment.

When CBT is coupled with mindfulness, such as MBCT, people with depression experience enhanced momentary positive emotions, appreciation, and responsiveness to pleasant daily-life activities (Geschwind, Peeters, Drukker, Os, & Wichers, 2011). This finding was a result of an empirical investigation of MBCT (n = 64) versus a control group (n = 66) with participants diagnosed with a life-time history of depression (Geschwind et al., 2011).

The latter finding may apply to problems gamblers as well because Geschwind et al. (2011) noted that their findings can generalize to most individuals with residual depressive symptoms and as previously noted, problem gamblers often experience mood disturbance (Kennedy et al., 2010). Thus, it appears MBCT has ample evidence supporting it as an appropriate intervention to be used with those seeking help with their gambling problems.

MBCT can be provided in both a group and individual format (Didonna, 2009), but a group format may have its benefits compared to individual sessions. The next section will address the effectiveness of group counselling for treating gambling addiction since the project is focused on applying MBCT within a group setting.

Effectiveness of Group Counselling for Treating Gambling Addiction

There has been little research conducted to determine the effectiveness of group therapy for gambling addiction, but there have been a few empirical studies that suggest group counselling as a viable treatment option. First, Carlbring, Jonsson, Josephson, and

Forsberg (2010) investigated two types of group therapy for the treatment of gambling and compared the results to no-treatment waitlist. Both forms of group therapy (motivational interviewing and CBT) were found to be significantly effective treatment options since no improvement was noted with the waitlist group (Carlbring et al., 2010). In addition, the authors reported the treatment gains were consistent at 12-month follow-up. Thus, group counselling appears to be a viable treatment option (Carlbring et al., 2010).

Additional evidence that group therapy is an appropriate form of intervention is drawn from the work of Myrseth, Litlere, Stoylen, and Pallesen's (2009). These authors examined the effectiveness of short-term group (using CBT) and compared the treatment to a no-treatment waitlist control group (Myrseth et al., 2009). Again, group therapy was found to be an effective treatment option for gambling addiction, as evidenced by significant improvement on all three variables (i.e., DSM-IV criteria for pathological gambling, money spent on gambling during the last week, and gamblers inventory of negative consequences) from pre-treatment to follow-up (Myrseth et al., 2009).

Another support of group therapy for problem gambling comes from the work of Piquette-Tomei, Norman, Corbin-Dwyer, and McCaslin (2008) who interviewed 15 women problem gamblers who participated in group therapy. The objective of the study was to find out the women's preferences for treatment. One of the qualitative findings revealed that the interviewed women perceived counselling groups as effective if it was accessible and if group meetings were specifically structured for gamblers (Piquette-Tomei et al., 2008). Aside from the empirical evidence that group therapy works as a viable option to reduce gambling behaviour, it is relevant to also explain how group

participants may also benefit from some of the universal factors associated with group attendance.

Yalom (2005) addressed universal factors to explain why counseling groups are effective. Individuals who enter therapy may believe that they are alone with their issues and experience a sense of uniqueness and social isolation (Yalom, 2005). Group therapy can provide a relief from this sense of uniqueness and social isolation as group members come to realize that others share in their discomfort, which can be validating (Yalom, 2005). Furthermore, individuals in group therapy may have hidden their issues out of shame, but realizing there are others who have the same dilemmas and experiences may lessen the shame (Yalom, 2005). Group members may even relate to each other in a manner that the group leader may be unable to; therefore, the group experience fulfills members' need for relatedness in a way that the group leader cannot provide (Yalom, 2005). Next, it is important for group leaders to consider the factor of universality in multicultural groups. For example, there may be cultural differences among group members (i.e., differing beliefs about disclosure, interaction, and expression of affect) that reinforce exclusions, but the idea of universalism may help members see the human similarities and learn to be accepting of diversity (Yalom, 2005).

Additionally, "group support can help keep practice going, partly due to having others around who practice mindfulness and believe in its value, thereby influencing subjective norms and behavioural beliefs" (Langdon, Jones, Hutton, & Holttum, 2011, p. 9). In the proposed group program, there is weekly homework thus having members be accountable for applying learning to their lives.

In order to foster productive learning within a group setting Yalom (2005) advised that PEGs should be characteristic of "partnership and collaboration, rather than prescription and subordination" (Yalom, 2005, p. 9). The latter learning environment encourages group members to learn from each other's experiences and provide hope for one another by sharing their successes (Yalom, 2005). This advice is followed in the proposed group program as interactive exercises have been developed to encourage participants to learn from each other.

This chapter demonstrated group therapy can be a successful treatment option for pathological gambling (Carlbring et al., 2010; Myrseth et al., 2009). In addition, this chapter reported results that supported MBCT as a viable intervention. Thus, the proposed group program has been developed keeping the latter factors in mind.

The next chapter will address the research methods utilized to complete this project such as the search terms and databases that were reviewed. The final chapter, before the proposed group is introduced, will present a brief synopsis followed by a discussion of the strengths, weaknesses and areas of future research associated with this project.

Chapter Four: Methods

This section, Chapter 4, outlines the research methods that were used to complete this project. Correspondingly, this chapter includes a synopsis of the literature reviewed, the search terms and databases that were reviewed, as well as statements of adherence to the American Psychological Association (APA) publication standards (American Psychological Association [APA], 2010), and statements of ethical conduct that were adhered to during the writing of this project.

Synopsis of the Literature Reviewed

This project explored a core body of the academic literature to fulfill the objective of a University of Lethbridge project as well as to serve as the theoretical foundation for the applied element of the project, found in Appendix A. In particular, the following areas were addressed in Chapters 2 and 3: (a) the definition and classification of problem gambling, (b) etiology of problem gambling, (c) comorbidity with other disorders, (d) prevalence of problem gambling, (e) psychosocial costs and consequences of problem gambling, (f) definition of mindfulness, (g) effectiveness of mindfulness, (h) relevance and effectiveness of mindfulness-based treatment for problem gambling, (i) group counselling best practices, and (j) effectiveness of group counselling for the treatment of problem gambling.

Search Terms and Databases Used

To complete the literature review the following electronic databases were used: PsychInfo, PsychArticles, and Internet resources such as Google Scholar. Search terms used included but were not limited to: gambling addiction, pathological gambling, Canadian prevalence, gambling revenue, mindfulness, mindfulness and gambling,

mindfulness and addiction, relapse prevention and gambling, and psychosocial costs of problem gambling. This project explored studies and materials from peer-reviewed journal articles, books, manuals, and workbooks that examined the impact and treatment of problem gambling in adults.

Statement of APA Adherence

The standards outlined in the *Publication Manual of the American Psychological Association* (APA, 2010) were strictly adhered to for the entire project. However, creative expression was used in the Appendix (e.g., use of copyright free pictures, use of non-APA directed headings, as well as the use of different font sizes, styles, and colours).

Statement of Ethical Conduct and Code of Ethics Used

I adhered to the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000; see also Sinclair & Pettifor, 2001). The group program adhered to the group therapy best practices as documented by the main American and Canadian group therapy associations—the Canadian Group Psychotherapy Association (Canadian Group Psychotherapy Foundation, 1995), Association for Specialists in Group Work (Thomas & Pender, 2008), and the American Group Psychotherapy Association (2007). Since no data collection was needed for this project, submission for ethics approval was not required. Portions of the Appendix for this project (i.e., the group manual) initially originated from a course assignment completed in partial fulfillment of a graduate-level course. However, since the course, I have significantly modified the group manual by expanding and refining the content to make the manual a comprehensive, detailed document.

Chapter Five: Synthesis

The premise of this project focuses around the importance of providing treatment to those struggling with gambling issues given the psychosocial costs of problem gambling, which involves negative impacts to various areas of life, such as health, relations, financial, legal, employment, and so on (Desai et al., 2007; Ferland et al., 2008; Hong et al., 2009; Smith & Wynne, 2002; Walker et al., 2006). Before introducing the proposed treatment a final chapter is necessary.

This chapter presents a synthesis of the literature review, which served as a foundation for the development of a 10-week group program for adults with problem gambling, which is found in Appendix A. The chapter also examines the strengths and limitations of the literature review presented in Chapters 2 and 3, including the strengths and limitations of the proposed group program. Suggestions for future research regarding the treatment of gambling addiction will also be discussed in the chapter. This project has the potential to be quite valuable as there has been no known published use of MBCT to specifically treat problematic gambling addiction.

Overview

The chapters in this project focused on gambling addiction and mindfulness-based group therapy. The second chapter focused on definitions, prevalence, etiology, psychosocial costs, mental health, and government-sponsored gambling. This provided a foundation for the presentation of a comprehensive, 10-lesson group manual for treating gambling addiction. It was necessary to outline how problematic gambling is determined according to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000), as these behaviors are characteristic for problem gamblers

who will attend the group program. For instance, the criteria for problem gambling includes gambling preoccupation, tolerance, uncontrollability, irritability present in the absence of gambling, chasing behaviour, lying, illegal activity, negative consequences to major life areas, and/or looking for bail out (American Psychiatric Association, 2000). To help distinguish between problem gambling and nonproblem gambling, the Problem Gambling Severity Index was introduced (Smith & Wynne, 2002). This tool has the potential to distinguish problem gamblers from nonproblem gamblers, since problem gamblers are more likely to suspect that they have a gambling issue due to negative consequences of their behaviour (Smith & Wynne, 2002).

Despite the negative consequences of gambling, this project reviewed why people with gambling problems continue to engage in this form of compulsive behaviour. Some of the reasons include dissociation, emotional regulation, to feel in control, to relax, and for excitement (Wood & Griffiths, 2007). Other factors that may put people at risk for problem gambling are cognitive vulnerability, family history of gambling or substance addiction, situational and structural characteristics of games, the rise of technology (i.e., online gambling increases addictive potential due to increase in various factors, such as accessibility and asociability), and mental health issues (Griffiths, 1993, 2003; Smith & Wynne, 2002; Wood & Griffiths, 2007). The latter risk factors are important to consider as these factors may surface in the proposed group program, which will need to be addressed.

Of particular relevance to counsellors are the mental health issues that may be associated with those who may engage in problem gambling. Gambling addiction correlates with various mental health concerns such as bipolar, anxiety, social phobia,

depression, suicidality, personality disorders, alcohol and other drug addictions, and smoking (Brooker et al., 2009; Kennedy et al., 2010; Seguin et al., 2010; Wiebe & Cox, 2001). The proposed group manual is suitable for those participants with mental health issues. However, there are screening criteria that must be met before a client can enroll in the group as it is recognized that the participants in a group program for gambling may present with mental health issues.

This project also examined which types of people are more at risk for engaging in problematic gambling behaviours. This information is important for a variety of reasons such as helping practitioners know who to target gambling treatment to. Demographically, more men than women have gambling problems, and people with problem gambling tend to be well educated and earn an average income (Smith & Wynne, 2002; Wiebe & Cox, 2001). Thus, practitioners need to consider cultural variables in choosing appropriate treatment.

It was recognized in Chapter 2 that Aboriginal populations tend to have a higher proportion of gambling issues compared to people of other ethnic backgrounds; therefore, attention was taken to ensure that multicultural issues are considered in the development and design of the proposed group program. For example, the Pregroup Session and Group Lesson 1 found in Appendix A address group expectations, which include openness and respect for cultural diversity. Respecting diversity is also covered with all group participants in the group's informed consent (Appendix B).

Chapter 3 overviewed a specific treatment method, mindfulness combined with CBT, to treat those with a problematic gambling history. This intervention serves as the core treatment foundation for the proposed group.

Mindfulness involves enhancing openness, acceptance, and curiosity of experience; it involves the practice of various meditative exercises in order to cultivate increased awareness of feelings, thoughts, behaviours, and the environment (Didonna, 2009; Kabat-Zinn, 2003; Lau & McMain, 2005). As documented in Chapter 3, mindfulness has been shown to be beneficial in various ways. For instance, mindfulness may serve as a way to regulate emotions, decrease reactivity, increase response flexibility, increase intrapersonal and interpersonal skills, enhance wellbeing, and increase treatment effectiveness for mood and other mental health disorders (Davis & Hayes, 2011; Hofmann et al., 2010). These benefits, it is assumed, will occur as a result of group members' completion of the proposed group on mindfulness (Appendix A).

In addition to mindfulness, CBT was incorporated into the group program based on the work of Toneatto et al. (2007) and Vallejo and Amaro (2009). This form of integration is referred to as MBCT, which may be delivered in a group format. In Chapter 3, evidence was provided that cognitive-behavioral group therapy has been found to be an effective treatment option for the treatment of gambling addiction (Carlbring et al., 2010; Myrseth et al., 2009).

The chapters in this project advocated that there is a substantial amount of literature that confirms that CBT and mindfulness may be combined to enhance the treatment of problem gambling (Geschwind et al., 2011; Lindberg et al., 2011; Sylvain et al., 1997; Toneatto et al., 2007; Vallejo & Amaro, 2009). Further, mindfulness has been shown to reduce impulsivity, and since gambling addiction is an impulse control disorder, it makes sense to use mindfulness-based strategies as a treatment approach (Peters et al., 2011). In addition, as people with gambling problems may have the tendency to

dissociate and have difficulty regulating emotions (Wood & Griffiths, 2007), it is logical to apply an intervention, like mindfulness, that involves enhancing emotional regulation (Didonna, 2009; Kabat-Zinn, 2003; Lau & McMain, 2005). The next section highlights the strengths of the proposed MBCT group program.

Strengths

There are many strengths associated with the proposed MBCT group program, which is located in the appendix. First, the treatment is offered in a group format. There are many benefits to offering group counselling to those with problem gambling, as documented in Chapter 3. For instance, it was reviewed that group therapy has been found to help reinforce learning of mindfulness, subjective norms, and beliefs among group participants in addiction recovery (Langdon et al., 2011). The latter finding offered support for the idea that a PEG may be a viable option for those in recovery from gambling addiction. A group format can also provide a safe avenue for people to meet those who are having similar struggles. This results in normalization, which may increase motivation for change and may expand the person's social network. Other strengths of the proposed group program include comprehensive lesson plans and increased accessibility.

Lesson plans. The strengths of the group program itself include well-designed lesson plans (Appendix A) that allow for group interaction, unique activities that acknowledge diversity and multicultural openness, innovative and current interventions, allows time for group process, and reflects current MBCT research. In addition, the lesson plans are well organized allowing the facilitators to anticipate what preparation work is required before each lesson.

In recognizing diversity, a variety of activities that cater to different learning styles was included within each proposed lesson. For example, verbal, visual, auditory, and body awareness exercises are incorporated into the manual to facilitate group members' learning of various skills. Further, group members are to be given ample breaks as this recognizes that some group members may need breaks to help them refocus on the content. Also, some people may learn best by having an informal discussion with other group members regarding the material learned in group while on a social break. In addition to recognizing diverse learning styles, exercises were incorporated into the manual to encourage group members to openly discuss issues from a multicultural perspective. For instance, the Pregroup Session ice breaker asks members to write one thing they are ashamed to admit about their gambling issue on a piece of paper, which they anonymously place in a box for other group members to select and read (Appendix A). One purpose of the activity is to demonstrate the shared experiences of group members despite their differences.

Furthermore, ample time for check-in, check-out, and time for process was allotted. Yalom (2005) noted that therapy groups should consist of a balance between process and content. Process is defined as "the nature of the relationship between interacting individuals-members and therapists" (Yalom, 2005, p. 143). Yalom spoke to the importance of the here-and-now of the group experience, which consists of two vital components. The first component is that current group events take precedence over current or past events outside the group (Yalom, 2005). The second component is that the group reflects on the here-and-now experience that had occurred (Yalom, 2005). Group leaders who acknowledge the relationship dynamics of group members are more

likely to achieve group goals even when the main group objective is noninterpersonal (Yalom, 2005). The lesson plans take this into consideration as it includes an assessment that group leaders complete at the end of every lesson to identify group process issues and solutions to those issues.

Recognition of process, along with the content of the group, is in line with a mindfulness orientation as both process and mindfulness involve a here-and-now orientation (Didonna, 2009; Yalom, 2005). The manual includes innovative and current cognitive therapy and mindfulness interventions. Chapter 2 presented a significant amount of material regarding the latter approaches that group leaders can refer to in order to have a strong understanding of the material they will teach to group members. For instance, cognitive therapy interventions involve showing group members how to identify and reconstruct maladaptive thoughts. Examples of mindfulness interventions included in the group program are mindful breathing, mindful eating, mindfulness of thoughts and feelings, the body scan, mindful hearing and seeing, among other exercises. In addition to well-designed lessons, the group program increases resources to problem gamblers.

Accessibility. An important strength of this project is it addressed the lack of resources in rural areas by designing a group program for problem gambling that potentially can fill the service gap in Northern Alberta. Also, the group program manual is designed to be used by counsellors who do not have the time or skill set to research or design a comprehensive group treatment plan. Providing counsellors, especially in rural areas, with a well-designed group program manual may increase services delivery to people with problem gambling who may not receive adequate services otherwise.

Overall, the strengths of the group program reflect a commitment to assisting group members learn material in a creative and engaging manner, which is based on available research. Despite the strengths of the project and literature review, there are limitations, which will be discussed in the next section.

Limitations

There are several limitations of the project and literature review, which are highlighted in this section. It is vital to discuss limitations, as it is recognized that the group program may not be implemented until a pilot study is conducted to determine the effectiveness of the group program and until the lesson plans are development taking into account the reported needs of group members and group facilitators. The limitations fall under two general categories: a narrow focus and no testing.

Narrow focus. To keep this project manageable in terms of its scope, the topics discussed were limited to how problem gambling impacts the adult problem gambler's life. Therefore, this project did not address how problem gambling may affect various groups of people such as adolescents, women, society and other individuals in the problem gambler's life, among other groups. Counsellors implementing the program may need to do additional research prior to running the program if the foundational information required is not covered in the literature review (i.e., if the majority of group members are women, a review of the literature on problem gambling and women may be necessary prior to conducting the group program). The program may not be generalizable to all populations, which is an important limitation to consider before applying the group program.

In addition, the main treatment focused on mindfulness and cognitive treatment approaches, but did not review other counselling modalities, such as motivation interviewing and family therapy, among others. This is a limitation as certain modalities, like motivational interviewing, are standard treatment approaches used in addiction counselling and may be effective at treating problem gambling, but it is absent from the literature review. It is important to note that other treatment modalities were omitted from the literature review not because they were deemed ineffective at treating problem gambling, but solely as a way of managing the scope of the project. Perhaps other treatment modalities are effective at treating gambling addiction and readers could misinterpret the omission of these modalities from the literature review as reflective of the ineffectiveness of other modalities.

No testing. The intent of this program was to design a group program with supporting evidence from current literature, which is a goal that was met. However, it was not a goal of this project to test the effectiveness of the group program. Therefore, a significant weakness of this project is not being able to state if the program will produce the desired change. Perhaps a mindfulness-based program may not be an effective treatment for gambling problems compared to other treatment approaches, such as CBT alone. In addition, no research was conducted to find out what clients want in a group program; having this information would be useful in order to enhance client satisfaction in the program. Moreover, no research was done to find out what counsellors need from a mindfulness group manual, which is a limitation as the program may not accommodate for counsellors' preferences thus making the application of the program unfeasible. Finally, no counsellors have reviewed the manual to determine if it is user friendly,

comprehensive enough to be a standalone document, and appropriate for their gambling clientele. Having the above mentioned information may make the applicability of the group program more effective. The next section highlights various ideas for future research regarding the group program.

Areas of Future Consideration

Considering the latter limitations of the literature review and group program, future research should aim to conduct a pilot to test the effectiveness of this group program for people with gambling problems. This suggestion is backed by a host of researchers such as Walsh and Shapiro (2006), who posited that criticisms against the empirical effectiveness of mindfulness in psychology tend to fall into three categories: limitations of treatment design (e.g., lack of control or comparison groups); subjects (e.g., small sample size or poor subject selection); and assessments utilized (e.g., overreliance on self-reports or mindfulness as a concept lacks empirically proven psychometric properties). This is similar to Papageorgiou and Wells's (2000) work, as they advocated for more randomized controlled trials to replicate findings.

Therefore, based on Walsh and Shapiro's (2006) recommendations, a series of questions should be addressed to determine the validity, reliability, and effectiveness of the program. First, does the program reveal significant pre- and posttesting differences? Do participants rate the program highly on content satisfaction? Do different client profiles do better with group? Does the amount of facilitator pre-training affect the program results? What impact do rural settings versus urban settings have on the program? How long should the group be (i.e., number of sessions, length of a session, etc.) and does this impact effectiveness? How do the counsellors' active support of

mindfulness impact the program? Despite the program's limitations and the need for further research, studies show that mindfulness based techniques are promising (Schreiner & Malcolm, 2008; Walsh & Shapiro, 2006).

Future research could also invite experts in the area of gambling do a comprehensive review of the manual to determine its potential value to group members. Experts or groups of counsellors could also be invited to assess if the design of the manual is user friendly for counsellors and contains an appropriate amount of information.

In addition, group members' feedback should be elicited to determine the applicability of the program (i.e., can group members use what they learn in the group to improve their lives), if lesson activities elicit a sense of belonging among group members, if the material is understandable, and so on. This could easily be implemented by using weekly feedback satisfaction forms (which are supplied in the group manual found in Appendix A). Counsellors could informally discuss the group feedback they receive each week and make the necessary adjustments. Ideally, qualitative interviews with all consenting participants including the facilitators of the program could be done to discover what could be added, omitted, or changed in some way to make the program better.

The proposed mindfulness group program to treat problem gambling makes an important contribution to the addiction and mental health field and it is a strong start to providing additional support, resources, and assistance to those with problem gambling. However, it is important that counsellors and researchers recognize that the group program should be implemented cautiously, as it has not been validated as an effective treatment approach for problem gambling and for specific populations (i.e., adolescents

and women with problem gambling, etc.). Overall, it is my hope that the manual will be widely distributed among counsellors who work directly with clients who have gambling problems and will be willing to engage in research to strengthen the program.

Reflection and Closing Remarks

Completing this project and reviewing problem gambling and its treatment has been a valuable learning experience for me, as both a student and addictions counsellor. I have come to the realization that there is much more to learn about problem gambling (i.e., problem gambling terminology, consequences of problem gambling for various groups, such as women, families, society, etc.) and treatment (effectiveness of therapies, barriers to service, etc.), which will serve me well in my career as an addictions counsellor. The treatment of problem gambling is not as straightforward as I previously thought, meaning that problem gamblers do not all present the same and problem gambling as a behaviour may be a symptom of another mental health concern, such as a personality disorder or impulse control disorder. As a result, I will need to remember to consider concurrent factors in maintaining problematic gambling behaviour, which may also guide treatment selection. Considering the various subtypes of problem gambling, I see the need for me (and counsellors in general) to be flexible when choosing treatment approaches to ensure the best approach to meet clients' needs.

My interest in group work was further strengthened in writing this project. Having been both a participant and leader of therapy groups, I have experienced the kind of magic that can occur when group cohesion is effectively created. For instance, as a group participant, group therapy differed from individual therapy because I had to be much more vulnerable to more people. In individual therapy I only had to be vulnerable

to my therapist and in the real world I can choose whom to be vulnerable to, but when I entered group, I had to open myself up to strangers. In opening myself up to vulnerability in a safe group environment, I learned a great deal about myself and others, including and not limited to how much more connected I am to others due to our shared humanity. As a group leader, I learned and continue to learn what Yalom (2005) discussed as universalism and how shared compassion can be healing. The activities in the group manual were specifically created as a process in which group members can experience this universalism and group cohesion.

It is my hope that the proposed MBCT group manual will assist group leaders in facilitating change through teaching process and MBCT content to those with problem gambling. Furthermore, not only do I hope that group members will learn and apply mindfulness practice as a means of healing from gambling addiction, but that they will experience mindfulness as a way of being fully present in their everyday lives. Hagen (1997) explained that it is "only in learning to see this very moment, as it has come to be, that liberation occurs—not in wearing robes or performing ritual acts" (p. 159). The mindfulness practices that group members will learn is not what will free them from the gambling fog, but rather it is experiencing life for what it is as it unfolds moment to moment.

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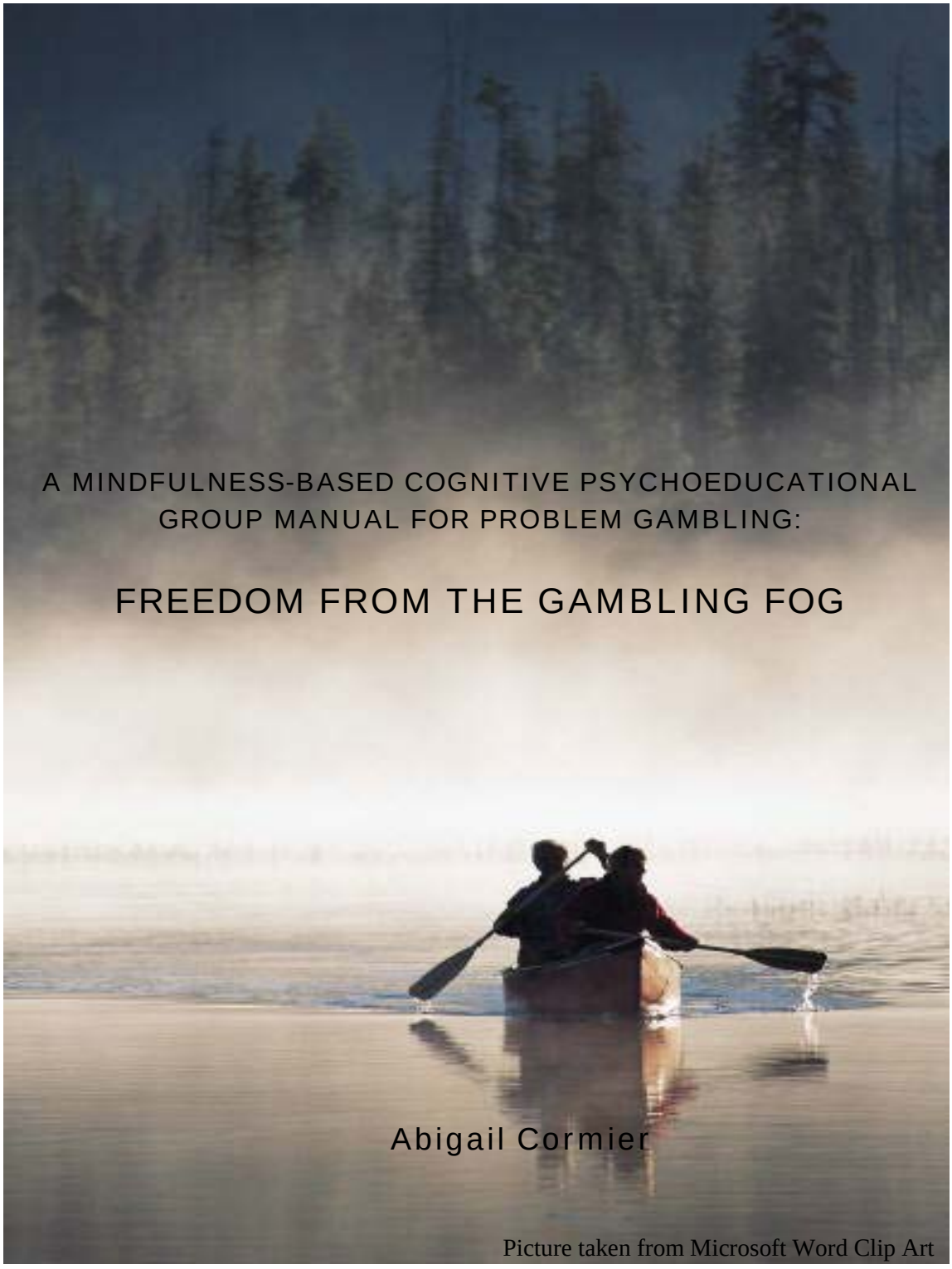
Appendix A


A MINDFULNESS-BASED COGNITIVE PSYCHOEDUCATIONAL GROUP MANUAL FOR PROBLEM GAMBLING:
FREEDOM FROM THE GAMBLING FOG
Abigail Cormier
Picture taken from Microsoft Word Clip Art

A MINDFULNESS-BASED COGNITIVE PSYCHOEDUCATIONAL GROUP MANUAL FOR PROBLEM GAMBLING: *FREEDOM FROM THE GAMBLING FOG*

Abigail Cormier
January 2012

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TABLE OF CONTENTS FOR THE GROUP COUNSELLING MANUAL

PREAMBLE

The intention of this mindfulness-based cognitive psychoeducational group (PEG) program is to provide counsellors with a resource for intervening with adults who have a gambling problem. The next section provides an overview of the group program and lesson plans, which will be followed by information regarding screening group members, ethical considerations, group structure, and lesson plans and facilitator notes.

OVERVIEW OF THE GROUP THERAPY PROGRAM AND LESSON PLANS

This manual includes sample lesson plans designed to assist counsellors in facilitating a mindfulness-based cognitive therapy PEG program for adults diagnosed with pathological gambling (see Chapter 2 for a review of pathological gambling). The lesson plans have been created specifically for adults with pathological gambling issues.

These lesson plans are intended to assist counsellors who already have a good understanding of group processes (see Chapter 3 for a review of the effectiveness of groups and Chapter 5 for a review of group benefits) and problem gambling. The lesson plans provide therapists with various tools to assist people with problem gambling in overcoming their addiction and improving their overall quality of life.

The lesson plans as previously indicated, follow a mindfulness-based cognitive therapy approach (see Chapter 3 for information on mindfulness-based cognitive therapy). Consequently, some of the lessons will educate clients about problem gambling and mindfulness-based cognitive therapy. Furthermore, a combination of mindfulness-based exercises and cognitive therapy interventions is offered to aid counsellors in guiding group members through their recovery from gambling addiction.

The following is an overview of the issues covered in this group program for problem gambling. The four main topics are as follows: (a) group screening; (b) ethical considerations; (c) group marketing; (d) and lesson plans.

GROUP SCREENING

This section will highlight the criteria for membership in the group program. A discussion regarding the use of specific assessment tools and the general screening process for the program will be covered as well.

In order to participate, group members must meet criteria for problem gambling determined by assessment tools, such as the South Oaks Gambling Screen (SOGS), the Problem Gambling Severity Index (PGSI) (Wynne, 2002), the Canadian Problem Gambling Index (CPGI) (Wynne, 2002) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) diagnostic criteria (see Chapter 2 for a review of diagnostic tools). Members may be referred to the group by their addiction counsellor, mental health therapist or through self-referral; counsellors may have already confirmed diagnostic criteria, in which case, participants may not need to complete these assessments again. If potential group members have not already completed appropriate assessments, then co-leaders can administer the necessary tools during the pre-screening interview.

ASSESSMENT TOOLS

This section highlights the most common assessment tools (i.e., PGSI, CPGI, SOGS, and DSM-IV-TR) used to assess problem gambling. Counsellors should ensure that they have the proper permission and training necessary to administer assessment tools in order to avoid any ethical issues involved in their use.

The Problem Gambling Severity Index (PGSI) (Wynne, 2002) comprises one section of the Canadian Problem Gambling Index (CPGI) (Wynne, 2002) and consists of nine self-report items, each followed by a 1-4 point Likert scale, pertaining to gambling activity in the last year. A total score of zero is indicative of non-problem gambling; 1-2 represents low risk for problem gambling; 3-7 represents moderate risk; and a score of 8 or above represents problem gambling. For the PGSI, Wynne reported a Cronbach alpha reliability coefficient of .84 and a test, re-test reliability Pearson Product-Moment correlation coefficient of .78. The PGSI also has strong concurrent validity with respect to the South Oaks Gambling Screen (SOGS) (Lesieur & Blume, 1987) (r = .83) and DSM-IV (r = .83) (Wynne, 2002).

Canadian Problem Gambling Index (CPGI) (Wynne, 2002) is a nine item index that accurately distinguishes among non-problem, at risk, and problem gamblers in the general population. Items are scored using a 4-point response scale (0 never, 1 sometimes, 2 most of the time, and 3 almost always) and summed to provide an index score where four categories are formed: 0 non-problem, 1–2 low-risk, 3–7 moderate-risk, and 8–27 problem gambling (Ferris & Wynne, 2001).

The South Oaks Gambling Screen (SOGS) is a 16-item questionnaire based on the criteria for pathological gambling from the DSMIII-R and is used to detect gambling problems (Lesieur & Blume, 1987). It has been shown to be a valid and reliable questionnaire. The SOGS has been utilized in various clinical and research applications with treatment and general populations (Lesieur & Blume, 1987).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) categorized pathological gambling as an impulse-control disorder with the main feature being “persistent and recurrent maladaptive gambling behavior (Criterion A) that disrupts personal, family, or vocational pursuits” (American Psychiatric Association, 2000, p. 671), which is not otherwise accounted for by a manic episode (Criterion B). Five of the 10 diagnostic criteria in the criterion A category need to be meet as well as the exclusion of manic behavior for an individual to be diagnosed with pathological gambling (American Psychiatric Association, 2000).

The Informational Biases Scale (IBS) (Jefferson, Doiron, Nicki & MacLean, 2004; Jefferson & Nicki, 2003) is a 25-item questionnaire using a 7-point Likert scale, which assesses faulty beliefs or cognitive distortions in VLT gamblers. Internal consistency or Cronbach alpha reliability is .92; all 25 items are adequately related to one factor for bar patrons (Jefferson & Nicki, 2003). Its construct validity is supported by being sufficiently correlated with the SOGS (r = .48) (Jefferson & Nicki, 2003).

Screening

Next, members should be voluntary participants and in preparation, action, or maintenance stage of change, which can be screened for by the co-leaders in the pre-screening interviews. Corey, Corey, and Corey (2010) noted that participants' motivational level for change should be considered during pre-screening. Mindfulness interventions can be a significant time commitment, since sessions are two hours weekly for eight weeks, possibly involving significant travel time, and many assigned homework exercises. This substantial time requirement may be inconvenient for participants (Kocovski, Segal, & Battista, 2009).

In addition, members who are actively suicidal or would benefit from one on one counselling or crisis counselling versus group counselling should not be selected for group participation, which can also be screened for by co-leaders in the pre-screening interviews. Clients who have brain-damage, paranoia, hypochondria, acute psychosis, and diagnosed with antisocial personality disorder should not be selected for membership as they are usually not good candidates for group work (Corey, Corey, & Callanan, 2007). Additionally, Corey, Corey, and Corey (2010) advised leaders to use clinical judgement when selecting members; therefore, co-leaders may use intuition and screening criteria to make decisions about group membership. Group membership decisions will depend on what is beneficial for individuals as well as the group as a whole.

Ethical Considerations

The group program should be conducted in an ethical and legal manner by adhering to the CPA code of ethics and your agency's code of conduct policy. The following CPA codes should be adhered to.

Canadian Code of Ethics for Psychologists

First, the principle of respect for the dignity of persons requires group leaders to treat group members with general respect, including respect for their general rights. Group members will not be discriminated against for any reason. Group members will be treated fairly and according to due process. Group members will review and sign an informed consent form (See Appendix B) during the pre-screening interview. Members have the right to refuse treatment or the freedom of consent. Leaders will protect vulnerable persons, ensure the privacy of group members is respected, and explain confidentiality and its' limits to group members. The running themes involved in the principle of responsible caring is competence and self-knowledge, risk/benefit analysis, maximize benefit and minimize harm, offset/correct harm, and address the care of animals. Group leaders will consult with the Canadian Group Psychotherapy Association to stay current with training, practice and research in group psychotherapy. Next, the principle of integrity in relationships requires group leaders to be accurate and honest, objective/lack bias, be straightforward/open, avoid incomplete disclosure, avoid conflicts of interest, and rely of the discipline. Lastly, the principle of responsibility to society requires group leader to develop knowledge, engage in beneficial activities, have respect for society, and be involved in the development of society (Sinclair & Pettifor, 2001).

Dual Roles

Next, it is vital that the group leaders handle dual roles/relationships with group members in an ethical fashion. For instance, dual roles may occur easily in a small town. If group leaders see group members in public, they will keep their identity private by not approaching them. If members decide to approach group leaders, they will be made aware of the risk in the informed consent form that others may become aware that they are a client, since the leaders' profession may be widely known. Additionally, group leaders will not provide individual counselling at the same time as group counselling as providing both services is considered a dual relationship (a relationship in which the counsellor h*as* more than one role of authority with clients), and can be harmful to clients. Group counsellors will maintain healthy boundaries by fostering professional relationship rather than becoming personal friends, and by limiting incidental contact they have with clients in the community (For further discussion regarding dual roles and ethics, please see Appendix B).

Legal Safeguards

Group leaders will take legal safeguards by adhering to the following suggested guidelines.

- Screen candidates carefully (see section on screening).
- Use informed consent and review it with clients (see informed consent in Appendix B).
- Document relevant client activity in case notes including termination or referrals (see section on client notes).
- Be aware and communicate limits of confidentiality (see informed consent in Appendix B).
- Limit practice to what leaders are qualified according to education, training, and experience.
- Abide by the CPA, best practice policy, and code of conduct of employer.
- Consult with appropriate parties (i.e., supervisor) when potential ethical dilemmas arise.
- Do not promise anything that cannot be delivered. Communicate that client commitment is vital for successful group experience.
- Practice appropriate boundaries with clients.
- Evaluate group effectiveness and teach clients how to assess their own progress.
- Assess and intervene appropriately in the case of client risk to self or others.
- Refer group member to different services when appropriate and required.
- Be aware of any countertransference issues that may negatively affect the group (see group leader self-evaluation at the end of each lesson).

- ❖ Refrain from meeting personal needs at the expense of the group (Corey, Corey, & Corey, 2010).

Informed Consent

Group members are to consent to group therapy after being fully informed, in print, of the terms of counselling. Included in informed consent involves the limits to confidentiality, which is vital for group participants to be aware of (see an example of an informed consent form in Appendix B).

Supervision

Group facilitators should be supervised to ensure an ethical and clinically sound practice. There may or may not be a cost for supervision depending if the counselling office has a supervisor on staff that can supervise the group leaders. At least one session should be live (directly observe the group), ideally by session 3 thereby allowing the therapists to make any corrective feedback and to ensure the leaders have a solid understanding of any hindering group dynamics. Another session can be videotaped which can be reviewed by the group leaders and two clips can be shown to the supervisor for feedback (i.e., a 15 min clip of strengths and another 15 min clip regarding areas of improvement) (McBride, 2011).

Group Structure

Client Feedback & Measurement of Client Satisfaction

After each group session, clients will complete a short client satisfaction form, which should take less than 5 minutes to complete. The latter will give co-leaders information regarding how the group is going and what needs to be modified to meet group members' needs (see Appendix C for a copy of a client satisfaction questionnaire).

Drop Out Policy

Group members have a right to quit the group (Corey, Corey, Corey, 2010), but the group leaders will encourage members to attend a few sessions before making their final decision if they are thinking of dropping out. During the pre-screening meeting, members will be informed that if they want to drop out, meaning that they will not complete the program for whatever reason, they need to inform the group leader in advance, so that the other members will have a chance to say goodbye. During the pre-screening, members will be informed that those who no show for two consecutive sessions will be contacted by group leaders.

Group Membership Expectations

During the pre-screening meeting, members will create group rules and guidelines (see Appendix D), which will become a contract for group membership. These guidelines will be discussed during the first group with all members as a reminder of what is expected. In addition to the guidelines that members come up with, group leaders will have a handout of rules and guidelines that are expected of members.

Facilitation Issues

Given there are many advantages to co-facilitation, the group can be co-led by two counsellors who have education and training in group facilitation, education and experience counselling those with gambling addiction, at least a couple of years' experience in group facilitation, have attended at least one group as a client, and have taken certified training in running a mindfulness-based program. The group facilitators should have personal experience applying mindfulness into their personal ways of being.

If a facilitator is unable to make it to a group session due to illness, the other leader will run the group for that week instead of cancelling. If both leaders are unable to make it to group, each group member will be contacted by the secretary at the contact number that group members have indicated on their intake forms. Group members will be made aware that the secretary could contact them in the case of group cancellation.

Fees

If the group is financially covered by health care or insurance company there may be no fees associated with group membership. If the group fee is not covered by the latter, counsellors need to ensure that payment requirements are laid out explicitly to prevent any confusion.

File Notes

The only name contained in each member's file is his or her own so that in the event of a file being subpoenaed, only that particular client's file is viewed, rather than the files of every group member. Client notes will be completed by the leaders after the group session has ended and entered into a secure documentation system on the computer in the counselling office using a standardized form.

McBride (2010) suggested that counsellors record relevant information, provide context, record behavior and discriminate between an observation and interpretation, the date and duration of session, the focus of the session, and what interventions were used. McBride's sample client note will be modified slightly for group members' client notes (see Appendix E).

Group Member Characteristics

The minimum amount of group members needed to form a group will be 3 to a maximum number of 8 participants. Counsellors will be aware of what primary language group members speak to ensure that members express comfort conversing in this language. Members may vary in cultural affiliation. Members will not be denied membership based on cultural affiliation.

Learning Diversity

Group leaders will consider that members may have different attention spans, learning styles, and may have learning disabilities. A combination of approaches will be used to meet clients'

needs, such as using visual and auditory materials and group exercises will include interactive and individual exercises. Handouts include both words and pictures to make it easy to read. If members have literacy issues, auditory materials will be made available. Any special learning requirements will be identified during the group pre-screening interview.

Length

The group will run for 2 hours once a week for 8 weeks. Members will be given a 15 minute break half way through the group. Pre and post group meetings are not included in the later time estimate. The group is a closed group, meaning that new members will not be added once the group commences. The pre-group meeting will occur 2 weeks before the group commences and post-group meeting will occur 2 weeks later.

Location & Room Set Up

The group will be held at a location easily accessible to participants. The building should be wheelchair accessible (i.e., the building is equipped with an elevator, wheelchair accessible washrooms, wide doorways, parking is available for those with disabilities, etc.). Parking is available in the vicinity of the building. The group meeting room is sound proof and in a private location inside the counselling office. The group room is a large room equipped with comfortable chairs that are laid out in a circle with Kleenex boxes, paper, pencils, and other interesting items located in the centre of the room. The beverages (water, tea, coffee, and juice) will be located in the group room on the side wall. Group leaders will have a flip chart with markers for occasional use to demonstrate concepts visually. There is a television set with a DVD /VHS player and a CD player off to one side of the room. Also, there is a clock on the wall for time management purposes.

Multicultural Diversity

Multicultural diversity is welcomed; it is open to all adults over the age of 18 regardless of sexual orientation, culture, religion, relationship status, race, ethnicity, colour, national origin, or disability. The group leaders will continuously develop three main multicultural counselling competencies. First, leaders will practice cultural self-awareness (i.e., active awareness of personal assumptions, values, and biases). Secondly, leaders will become aware of clients' cultural identities (i.e., understanding the worldview of the client). Lastly, leaders will develop a culturally sensitive working alliance (Arthur & Collins, 2010). Leaders will role model the latter competencies for members of the group and encourage acceptance of diversity (Corey, Corey, & Corey, 2010).

Prep and Debriefing Time for Facilitators

Group leaders will prep for 1 hour before group (i.e., prepare handouts and discuss with co-leader the session goals and any issues leaders should bring up from prior sessions). Session debriefing will occur after each group for 1 hour. Topics that will be debriefed will depend on the stage of the group. During the Pre-screening, leaders will discuss their philosophies, leadership styles, develop an alliance, expectations of one another, and so on. Other topics leaders may discuss with each other are strengths and weakness, views of practicing ethically, and how support can be provided. During the working stage of the group leaders can focus on evaluating the group, discuss techniques, talk about self-disclosure issues and confrontation issues, and so on. Some questions that could be asked are "how is the group going", "what is going well and not so well", "what barriers are arising in the use of interventions", and "what countertransference issues are coming up" (Corey, Corey, & Corey, 2010).

Group Marketing

The group can be marketed to men and women who are experiencing gambling problems by posting a marketing poster (See Appendix F) on bulletin boards at local supermarkets, mental health and medical clinics, addiction services offices, casinos, bingo halls, and other local restaurants where slots and VLTs are located. Permission should be granted by establishment owners prior to posting marketing posters.

The next section includes an overview of the 8 lesson plans, including group goals, objectives, and how these goals will be evaluated.

Overview of Lesson Plans

Group Goals, Objectives, and Evaluation

Overall Most Relevant Group Goals	Related Objectives (Tasks) that Align with the Overall Group Goals	Measurement (Evaluation) of the Goal & Corresponding Objectives
1. Increase awareness and respond differently to negative thoughts, emotions that trigger gambling behavior (Sylvain, Ladouceur, & Boisvert, 1997; Smith & Wynne, 2002). For more information on how faulty beliefs maintain gambling problems refer to Chapters 2 and 3.	1a. Identify dysfunctional thoughts that lead to gambling behaviour. 1b. Replace dysunctional thoughts with more adaptive thoughts in thought record.	1a. Lowered post-test scores compared to pre-test on the Informational Biases Scale (IBS), which is a valid and reliable scale measuring irrational gambling cognitions (Jefferson, Doiron, Nicki & MacLean, 2004; Jefferson & Nicki, 2003). 1b. Dysfunctional thoughts related to gambling are identified and reconstructed in thought record provided.
2. Increase mindful awareness of experience, increase distress tolerance, and reduce avoidance of experience (Barnhofer & Crane, 2009; Bien, 2009). See Chapter 3 for more information on the effectiveness of mindfulness.	2a. Increase awareness of the body by engaging in the body scan, increase awareness of experience by engaging in mindful breathing, mindfulness of objects, sounds, thoughts, and feelings exercises.	2a. Increased post-test scores on the Mindful Attention Awareness Scale (MAAS) (Brown, 2003) compared to pre-test.
3. Become familiar with relapse warning signs and triggers specific to gambling relapse (Vallejo & Amaro, 2009).	3a. Identify 6 individual relapse warning signs and 6 individual relapse triggers. 3b. Develop a plan to implement in such situations.	3a. Client is able to list 6 individual warning signs and 6 triggers. 3b. Client is able to come up with a realistic plan of action when warning signs and triggers occur.

OVERVIEW OF SESSION TOPICS

Lesson Week & Topic	**Exercises**	**Handouts**
Lesson 1: Introduction to the group.	Introduction: a. Reminder of group objectives. b. Refresher of the group guidelines and group schedule. c. Ice Breaker in Dyads: Introduction and Hopes. d. Awareness Exercise	Lesson 1 Handouts b. Group Guidelines (Appendix D) Group Schedule (Appendix G) Handouts c. S.M.A.R.T Goals Handout (see Appendix U) Therapy Goals Handout (see Appendix V)
Lesson 2: What is Problem Gambling?	a. Team Building Activity: Past, Present, and Future b. Problem Gambling Characteristics c. Phases of Gambling Addiction d. Stages of Change e. Recovery Process	Lesson 2 Gambling Handouts a. Past, Present, and Future Handout (see Appendix T) b. Problem Gambling Characteristics Handout (see Appendix H) c. Phases of Problem Gambling and Recovery Handout (see Appendix I) d. Stages of Change Handout (see Appendix J) e. Where am I with my gambling problem? Handout (see Appendix K) Gambling Recovery Signs Handout (see Appendix M)

Lesson Week & Topic	**Exercises**	**Handouts**
Lesson 3: Introduction to Mindfulness	a. What is Mindfulness? b. Mindfulness Rationale c. Mindfulness Exercises: 1. Mindful Breathing Exercise 2. Body Scan Exercise 3.Mindful Eating	Lesson 3 Handouts a. Mindfulness Handout (see Appendix O) b. Mindfulness Rationale Handout (see Appendix P) c. Mindful Breathing Handout (see Appendix O)
Lesson 4: Introduction to Mindfulness continued	Mindfulness Exercises: 4. Seeing Meditation 5. Hearing Meditation 6. Mindfulness of Objects, Thoughts, and Feelings Exercise 7. Mindful Walking	Lesson 4 Handouts 6. The Visitor Handout (see Appendix Q) 6. Mindfulness of Feelings Handouts (see Appendix O & R) 6. Mindfulness Visuals Handout (see Appendix S)

Lesson Week & Topic	**Exercises**	**Handouts**
Lesson 5: Introduction to Cognitive Therapy	a. What is Cognitive Therapy? b. Reminder of the Gambling Cycle c. Identifying Dysfunctional Gambling Thoughts Exercise d. Reconstructing Dysfunctional Gambling Thoughts Exercise	Lesson 5 Handouts b. Gambling Cycle (see Appendix X) c. Irrational thoughts about gambling handout (see Appendix N) d. Gambling Thought Record Handout (see Appendix W)
Lesson 6: Relapse Prevention for Gambling	a. Identify Triggers and Warning Signs Exercise b. Create Action Plan Exercise (split group into teams) c. Behavioral Rehearsal Exercise	Lesson 6 Handouts a. Warning Signs Handout (see Appendix Y) b. Gambling Recovery Signs Handout (see Appendix M)

Lesson Week & Topic	**Exercises**	**Handouts**
Lesson 7: Applying Learning. Reflection and Feedback	a. Applying Learning Exercise b. Reflection Exercise c. Reflection Journal	Lesson 7 Handouts: a. Since I quit gambling Handout (see Appendix L)
Lesson 8: Closure	a. Review Feedback Journals b. Reminder Object Exercise c. Process Group Closure	Lesson 8 Reflection Journal Reminder Object (i.e., Rock)

Lesson Plans and Facilitator Notes

Pre-Group Session

Duration: 2 hours

Objectives of Pre-Group Session:

1. Welcome group members to the group program.
2. Review the overall group objectives.
3. Explain the group schedule.
4. Review the group housekeeping details.
5. Review group guidelines/expectations.
6. Introduction of group members.

Pre-Group Exercises:

1. Group Guidelines/Expectations Exercise
2. Icebreaker Exercise

Handouts:

1. Member Expectation Handout (see Appendix D).

Welcome the group members: Duration: 5 minutes

This eight week psychoeducational counselling group is intended to help individuals whose lives are being affected by problem gambling. If you are experiencing negative consequences as a result of gambling, this group is for you. The group will provide you with tools that you will need for your recovery and the information you will learn will help you to understand your gambling behaviour. Another key purpose of the group is to provide you with support from the facilitator and the other group members. This support may enhance your motivation to implement and achieve your group goals.

OBJECTIVES: DURATION: 5 MINUTES

*Have objectives and schedule prepared prior to group on Flip Chart.

The overall goal of group is to provide a supportive environment for people who have a gambling problem.

1. Increase social support through the group experience (Yalom, 2005).

2. Increase awareness and respond differently to negative thoughts, emotions that trigger gambling behavior and learn to respond appropriately (Sylvain, Ladouceur, & Boisvert, 1997; Smith & Wynne, 2002).

3. Increase mindful awareness of experience, increase tolerance to emotional distress, and reduce avoidance of experience (Barnhofer & Crane, 2009; Bien, 2009).

4. Become familiar with relapse warning signs and triggers specific to gambling relapse and learn how to deal with them (Vallejo & Amaro, 2009).

GROUP SCHEDULE: DURATION: 5 MINUTES

Provide group members with Group Schedule Handout (see Appendix G) and review.

Lesson 1: Group Introduction
Lesson 2: What is Problem Gambling?
Lesson 3: Introduction to Mindfulness
Lesson 4: Introduction to Mindfulness continued
Lesson 5: Introduction to CBT
Lesson 6: Relapse Prevention
Lesson 7: Apply Learning, Reflection & Feedback
Lesson 8: Closure

HOUSEKEEPING DURATION: 5 MINUTES

Present basic housekeeping information: scheduling, break times, location of washroom facilities, and so on. Discuss the following topics:

- The program is eight weeks. Two hours per session, starting and ending on time.
- You will be encouraged to participate by sharing your experience, asking questions, and providing supportive feedback to other group members.
- You will listen to short presentations; participate in learning activities, role plays, and discussions; complete in-session exercises; and have exercises to practice at home.

BRIEF INTRODUCTIONS: DURATION: 15 MINUTES

Introduce this activity by explaining the purpose of it is for brief introductions. Ask group members to state their name and one thing interests them (e.g., hobby, TV show).

GROUP GUIDELINES: DURATION: 30 MINUTES

Review Member Expectation Handout (see Appendix D). Ask members to contribute to the handout by sharing their own expectations (jot down group members' expectations on flip chart).

Debrief Exercise (5 Minutes); Ask group members what it was like to discuss guidelines.

BREAK DURATION: 15 MINUTES

ICE BREAKER DURATION: 30 MINUTES

Introduce this activity by stating the purpose of it is to get to know each other, to demonstrate the shared experiences of group members despite their differences, and to reduce shame and stigma attached to gambling addiction (5 minutes).

Ask each member to write something (pass out paper and markers) about their gambling issue that they are ashamed to admit on a piece of paper that they fold up and anonymously place in a box. Instruct group members to introduce themselves by stating their name and to choose a piece of paper out of the box and read it to the group (20 minutes).

Debrief Exercise (5 minutes): Ask group members what it was like to engage in this activity, to hear what other people are ashamed of, and to see how others have similar experiences despite differences.

CHECK OUT: DURATION: 5 MINUTES

Ask group members how the pre-group session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the pre-group session and note what will be covered next session. Remind group members of date, time, and place of next session.

LESSON 1: GROUP INTRODUCTION

DURATION: 2 hours

OBJECTIVES:

1. Review of Pre-Group Session (Objectives, Schedule, Guidelines)
2. Help members discover that the group program can be a safe, respectful place to learn and share
3. Establish group member goals
4. Increase awareness and increase trust among group members

LESSON 1 EXERCISES:

a. Reminder of group objectives, group schedule, and group guidelines.
b. Ice Breaker: Introduction and Hopes
c. Awareness Exercise

INTRODUCTION TO LESSON 1: DURATION: 15 MINUTES

Recap Pre-Group Session (5 Minutes) & Reminder of group guidelines (See Appendix D).

Review Lesson 1 objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

ICE BREAKER: DURATION: 50 MINUTES

Introduce this activity by explaining that the purpose is to encourage participants to set goals for group, which will give them direction. Explain that their goals should follow **S.M.A.R.T** guidelines (15 Minutes). See Appendix U for a review of the latter. Ask for volunteers to read parts of the handout.

In Dyads, members will discuss what they hope to get out of the group experience and on the handout provided (see Appendix V), write those goals down (20 Minutes) then; they will join the larger group to report on what was shared in dyads (10 Minutes).

Debrief Exercise (5 Minutes): Ask group members how it was for them to do this exercise.

BREAK: DURATION: 15 MINUTES

AWARENESS EXERCISE: DURATION: 25 MINUTES

Objective: to increase members' awareness of the group space, who is in the room, and any feelings and thoughts about being in the group here-and-now. Members are in the group stage where trust needs to be established and fears/insecurities are high.

Script: "Now, that we are back from break, I want you to look around the room and notice who is around, any sounds or sights, and any feelings or thoughts you are having. Take a moment to absorb what you're experiencing, either bad, good, or neutral. We're going to take a few minutes to discuss your observations. What are you noticing right here, right now?" Note: Read the script slowly and in a normal voice tone.

Ensure each member has a chance to share their current experience. If members are quiet, do a round.

Debrief Exercise: How did you find this exercise? What was it like to observe your here-and-now experience? What was it like hearing other members' here-and-now experiences?

CHECK OUT: DURATION: 5 MINUTES

Ask group members how the first session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the first session and note what will be covered next session. Remind group members of date, time, and place of next session.

SESSION EVALUATION: DURATION: 5 MINUTES

Hand out the session evaluation (see Appendix C) to each group member and inform them that their responses are anonymous, therefore; they do not need to put their name on the form. Instruct members to complete the form and when complete, they can flip it over in a designated location.

Session 1: Co-leader Debriefing

*Complete Session note for each group member (see Appendix E).

Discussion Questions:

1. How did the first session go; what went well and not so well?

_____
_____

2. What were your feelings, thoughts during the group regarding the group process?

_____
_____

3. What were your impressions of group members?

_____
_____

4. What personal feelings do I have regarding members?

_____
_____

5. How did co-leadership go the first session?

_____
_____

6. What went well and not so well regarding co-leadership?

_____
_____

7. What needs to change in order for co-leadership to run more smoothly?

_____
_____

8. What changes would I like to make to improve my leadership skills for next session?

_____
_____

9. Where do members appear to be regarding their stage in the group process?

_____
_____

10. What do I need to do for next session to ensure group members remain safe?

_____
_____

Lesson 2: What is Problem Gambling?

Duration: 2 hours

Objectives:

1. Define problem gambling
2. Explain phases of gambling addiction
3. Discuss the stages of change
4. Increase members' understanding of the recovery process
5. Continue to increase trust and safety among group members

Lesson 2 Exercises:

a. Team building Activity: Past, Present, and Future
b. Problem Gambling Characteristics
c. Phases of Gambling Addiction
d. Stages of Change
e. Recovery Process

Handouts:

a. Team building Activity: Past, Present, and Future Handout (See Appendix T)
b. Problem Gambling Characteristics Handout (See Appendix H)
c. Phases of Problem Gambling and Recovery Handout (See Appendix I)
d. Stages of Change Handout (see Appendix J)
e. "Where am I with my gambling problem?" Handout (See Appendix K) &
Gambling Recovery Signs Handout (See Appendix M)

Introduction To Lesson 2: Duration: 15 Minutes

Recap Lesson 1 (5 Minutes)

Review Lesson 2 objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

Team building Activity: Duration: 15 Minutes

Past, Present, and Future Activity (See Appendix T for full activity instructions)

Problem Gambling Characteristics: Duration: 15 Minutes

Review the Problem Gambling Characteristics Handout (See Appendix H) with group members (5 Minutes). Ask for volunteers to read the handout.

Ask group members which characteristics they identify with and why (5 Minutes).

Debrief Exercise (5 Minutes): Ask group members what is was like for them to discuss problem gambling characteristics

Phases of Gambling Addiction: Duration: 15 Minutes

Review the Phases of Problem Gambling and Recovery Handout (See Appendix I) with group members (5 Minutes).

Ask group members to assess themselves regarding where they are in the phases of problem gambling and discuss the result of his and her assessments (5 Minutes).

Debrief Exercise (5 Minutes): Ask group members what is was like for them to discuss the phases of problem gambling.

BREAK: Duration: 15 Minutes

Stages of Change: Duration: 15 Minutes

Review the Stages of Change Handout (See Appendix J) with group members (5 Minutes).

Ask group members to assess themselves regarding their stage of change and discuss it with a partner (5 Minutes).

Debrief Exercise (5 Minutes): Ask group members what is was like for them to discuss the stages of change.

Recovery Process: Duration: 15 Minutes

Review the “Where am I with my gambling problem?” Handout (See Appendix K) and the Gambling Recovery Signs Handout (See Appendix M) with group members (5 Minutes).

Ask group members to assess and discuss where they are at with their gambling problem and recovery (5 Minutes). Note that group members may be at different points in their recovery journey and that is normal, which should be explained to members.

Debrief Exercise (5 Minutes): Ask group members what is was like for them to discuss signs of recovery.

CHECK OUT: DURATION: 5 MINUTES

Ask group members how the second session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the second session and note what will be covered next session. Remind group members of date, time, and place of next session.

SESSION EVALUATION: DURATION: 5 MINUTES

Hand out the session evaluation (see Appendix C) to each group member and inform them that their responses are anonymous, therefore; they do not need to put their name on the form. Instruct members to complete the form and when complete, they can flip it over in a designated location.

Session 2: Co-leader Debriefing

*Complete Session note for each group member (see Appendix E).
Discussion Questions:

1. How did the second session go; what went well and not so well?

_____
_____

2. What were your feelings, thoughts during the group regarding the group process?

_____
_____

3. What were your impressions of group members?

_____
_____

4. What personal feelings do I have regarding members?

_____
_____

5. How did co-leadership go this session?

_____
_____

6. What went well and not so well regarding co-leadership?

_____
_____

7. What needs to change in order for co-leadership to run more smoothly?

_____
_____

8. What changes would I like to make to improve my leadership skills for next session?

_____
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9. Where do members appear to be regarding their stage in the group process?

_____
_____

10. What do I need to do for next session to ensure group members remain safe?

_____
_____

Lesson 3: Intro to Mindfulness

Duration: 2 hours

Objectives:

1. Educate group members about mindfulness and its benefits.
2. Increase group members' mindfulness by introducing various mindfulness exercises.

Lesson 3 Exercises:

a. What is Mindfulness?
b. Mindfulness Rationale and Hindrances
c. Mindfulness Exercises:
    1. Mindful Breathing
    2. Body Scan
    3. Mindful Eating

Handouts:

a. Intro to Mindfulness Handout (Appendix O)
b. Mindfulness Rationale Handout (Appendix P)
c. Mindful Breathing Handout (Appendix O)

Introduction To Lesson 3: Duration: 15 Minutes

Recap Lesson 2 (5 Minutes)

Review Lesson 3 objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

What is Mindfulness: Duration: 15 Minutes

Review the Introduction to Mindfulness Handout (see Appendix O) with group members (5 Minutes). Ask for volunteers to read the handout.
Assess group members' current level of mindful awareness (5 Minutes) using the Mindful Attention Awareness Scale (MAAS) (Brown, 2003). Pre-test scores will be used to compare to group members' post-test scores in the post-group session.
Debrief Exercise (5 Minutes): Ask group members what their thoughts are about mindfulness and what their scores are on the MAAS.

MINDFULNESS RATIONALE: DURATION: 15 MINUTES

Since some clients may have predetermined views of what mindfulness involves and may critique it as an inapt tactic, explaining what mindfulness entails and how it is an appropriate method may clear up any misunderstandings (Kocovski et al., 2009). Review the Mindfulness Rationale Handout (Appendix P) with group members.

An additional consideration when using mindfulness-based strategies is to warn clients of the common hindrances to being mindful. Review the following hindrances of learning mindfulness with group members:

Common challenges when practicing mindfulness exercises are:

1. Desire—wanting things to be different right away
2. Aversion—resisting the experience of the present moment
3. Sleepiness—resistance to painful thoughts or emotions
4. Restlessness—a distracting flood of thoughts and emotions,
5. Doubt—feelings of fear and hopelessness, and (McKay, Wood, & Brantley, 2007)
6. Time Commitment—Modify exercises as needed (For instance, instead of doing meditation for 15 minutes daily, reduce it to five minutes every second day so it is more manageable).

Debrief Exercise (5 Minutes): Ask group members what they believe will hinder them from engaging in mindfulness.

BREAK: DURATION: 15 MINUTES

MINDFULNESS EXERCISES: DURATION: 45 MINUTES

Introduce these exercise by explaining that the exercises they will practice will help them to increase awareness of experience and remind them of why it is important to do so (refer to mindfulness rationale). Make sure to follow the order in which the meditative exercises are laid out as it is to be taught in a gradual progression, starting with the most basic breathing exercise and so on.

1. Mindful Breathing: 10 Minutes

   Use Mindful Breathing Handout (Appendix O) to guide meditation
   (Read script at a slow pace using a normal voice tone, but not too loud or quiet).

   Debrief Exercise (5 Minutes): Ask members how they found this exercise.

2. Body Scan: 10 Minutes

   Play track 4 from Jon Kabat-Zinn's *Mindfulness for Beginners* CD.

   Debrief Exercise (5 Minutes): Ask members to describe how their body felt and how they found this exercise.

3. Mindful Eating: 10 Minutes

   Pass around raisins (ensure no one is allergic to raisins and if so provide an alternate, such as a jelly bean, etc.) to group members before guiding this meditation.
   Play track 2 from Jon Kabat-Zinn's *Mindfulness for Beginners* CD.

   Debrief Exercise (5 Minutes): Ask members how they found this exercise.

CHECK OUT: DURATION: 5 MINUTES

Ask group members how the third session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the third session and note what will be covered next session. Remind group members of date, time, and place of next session.

Assign Homework: Practice one of the exercises learned today for 5 minutes three times this week or modify practice time as needed. Remind group members that they can refer to their handouts for a refresher of the various meditative exercises.

SESSION EVALUATION: DURATION: 5 MINUTES

Hand out the session evaluation (see Appendix C) to each group member and inform them that their responses are anonymous, therefore; they do not need to put their name on the form. Instruct members to complete the form and when complete, they can flip it over in a designated location.

Session 3: Co-leader Debriefing

*Complete Session note for each group member (see Appendix E).
Discussion Questions:

1. How did the third session go; what went well and not so well?

_____
_____

2. What were your feelings, thoughts during the group regarding the group process?

_____
_____

3. What were your impressions of group members?

_____
_____

4. What personal feelings do I have regarding members?

_____
_____

5. How did co-leadership go this session?

_____
_____

6. What went well and not so well regarding co-leadership?

_____
_____

7. What needs to change in order for co-leadership to run more smoothly?

_____
_____

8. What changes would I like to make to improve my leadership skills for next session?

_____
_____

9. Where do members appear to be regarding their stage in the group process?

_____
_____

10. What do I need to do for next session to ensure group members remain safe?

_____
_____

Lesson 4: Intro to Mindfulness

Duration: 2 hours

Objectives:

1. Educate group members about mindfulness and its benefits.
2. Increase group members' mindfulness by exposing them to various mindfulness exercises.

Lesson 4 Exercises:

a. Seeing Meditation/Hearing Meditation
b. Mindfulness of Objects, Thoughts, and Feelings Exercise
c. Mindful Walking

Handouts:

a. The Visitor Handout (Appendix Q)
b. Mindfulness of Feelings Handout (Appendix R and Appendix O)
c. Mindfulness Visuals Exercise (Appendix S)

Introduction To Lesson 4: Duration: 15 Minutes

Recap Lesson 3 and ask how group members made out with homework (5 Minutes)

Review Lesson 4 objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

Seeing & Hearing Meditation: Duration: 20 Minutes

1. Seeing Meditation (10 Minutes)

   Script: Take a look around the room and take in what you see. Take notice of the details, any colors, textures, and so on. Look at what is in front, on each side, up and down, and behind you. What do you see? (5 Minutes)

   Debrief Exercise (5 Minutes): Discuss what group members saw and how they found this exercise.

2. Hearing Meditation (10 Minutes)

   Play Instrumental music that includes sounds of several instruments (i.e., music by Sigur Ros or Ratatat includes sounds of many instruments). Ask group members to pay specific attention to the sounds that they hear (5 Minutes).

   Debrief Exercise (5 Minutes): Discuss what sounds participants heard and what is what like for them to engage in this activity.

BREAK: DURATION: 15 MINUTES

MINDFULNESS OF OBJECTS: DURATION: 20 MINUTES

1. Pass around a basket with various objects and instruct group members to select an object out of the basket.

   Script: What does your object feel like in your hands? Notice the weight of your object. Notice the texture; is it soft, rough, smooth, and so on? What color is your object? Does it have a smell? Pay attention to what your object looks and feels like in your hands (5 Minutes).

   Debrief Exercise (5 Minutes): Ask members to describe their objects and what it was like for them to pay attention in this way.

2. Pass around paper and markers. Ask participants to draw any object and to include as much detail as possible. Inform group members that the purpose of this exercise is not to create a perfect picture, but just to bring attention to the details of an object (5 minutes).

   Debrief Exercise (5 Minutes): Ask members to describe their objects and what it was like for them to pay attention in this way.

MINDFULNESS OF THOUGHTS & FEELINGS: DURATION: 25 MINUTES

Review the Visitor Handout (Appendix Q), Mindfulness of Feelings Handouts (Appendix R and Appendix O) with participants to introduce this activity (5 Minutes). Ask for volunteers to read the handouts.

1. Mindfulness Visuals Exercise (see Appendix S)

   Pass out the handouts and ask members to voluntarily read the various mindfulness visuals (5 Minutes).

Debrief Exercise (5 Minutes): What visuals work for group members? What were members' reactions during mediation or about the meditation exercise? Explore members' reactions.

2. Play track 5 from Jon Kabat-Zinn's *Mindfulness for Beginners* CD (fast forward to the thoughts and feelings section of the meditation (5 Minutes).

   Debrief Exercise (5 Minutes): Ask participants to describe thoughts and feelings they noticed and what it was like to engage in this meditation.

MINDFUL WALKING: DURATION: 10 MINUTES

Ask members to walk slowly around the room while paying attention to sights, sounds, thoughts, feelings, objects, body, breathing, and so on (5 Minutes).

Debrief Exercise (5 Minutes): Ask group members how their bodies felt walking around the room; what sights, sounds, thoughts, feelings, objects, body, breathing, and so on did they noticed.

CHECK OUT: DURATION: 5 MINUTES

Ask group members how the fourth session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the fourth session and note what will be covered next session. Remind group members of date, time, and place of next session.

Assign Homework: Practice one of the exercises learned today for 5 minutes three times this week or modify practice time as needed. Remind group members that they can refer to their handouts for a refresher of the various meditative exercises.

SESSION EVALUATION: DURATION: 5 MINUTES

Hand out the session evaluation (see Appendix C) to each group member and inform them that their responses are anonymous, therefore; they do not need to put their name on the form. Instruct members to complete the form and when complete, they can flip it over in a designated location.

Session 4: Co-leader Debriefing

*Complete Session note for each group member (see Appendix E).
Discussion Questions:

1. How did the fourth session go; what went well and not so well?

_____
_____

2. What were your feelings, thoughts during the group regarding the group process?

_____
_____

3. What were your impressions of group members?

_____
_____

4. What personal feelings do I have regarding members?

_____
_____

5. How did co-leadership go this session?

_____
_____

6. What went well and not so well regarding co-leadership?

_____
_____

7. What needs to change in order for co-leadership to run more smoothly?

_____
_____

8. What changes would I like to make to improve my leadership skills for next session?

_____
_____

9. Where do members appear to be regarding their stage in the group process?

_____
_____

10. What do I need to do for next session to ensure group members remain safe?

_____
_____

Lesson 5: Intro to Cognitive Therapy

Duration: 2 hours

Objectives:

1. To educate group members about the gambling cycle and how to break that cycle.
2. To educate group members how to identify and reconstruct dysfunctional gambling thoughts.

Lesson 5 Exercises:

a. What is Cognitive Therapy?
b. Reminder of the Gambling Cycle
c. Identifying Dysfunctional Gambling Thoughts Exercise.
d. Reconstructing Dysfunctional Gambling Thoughts Exercise.

Handouts:

a. Gambling Cycle (Appendix X)
b. Irrational thoughts about gambling handout (Appendix N)
c. Gambling Thought Record Handout (Appendix W)

Introduction To Lesson 5: Duration: 15 Minutes

Recap Lesson 4 and ask how group members made out with homework (5 Minutes)

Review Lesson 5 objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

What is Cognitive Therapy? Duration: 15 Minutes

Cognitive Therapy involves interventions or exercises that are designed to help people change how they feel and act by reconstructing unhealthy beliefs. Cognitive therapy is present focused and does not require reflection of the past for answers (Corey, 2009).

Rationale: Cognitive therapy involves identifying certain dysfunctional beliefs that are related to problem gambling and changing those particular thoughts. By changing specific dysfunctional thoughts about gambling and replacing it with alternate more realistic thoughts, people are less likely to gamble (5 Minutes).

Review the Gambling Cycle handout (Appendix X) to tie in how cognitive therapy applies to helping group members break that cycle (5 Minutes).

Debrief Exercise (5 Minutes): Ask members to discuss the gambling cycle and share when they have been stuck in the cycle.

IDENTIFYING IRRATIONAL THOUGHTS EXERCISE: DURATION: 25 MINUTES

Introduce the exercise by explaining the importance of identifying irrational thoughts, such as it leads to gambling behavior. See Appendix N for a review of the Irrational Thoughts about Gambling handout (5 Minutes).

Instruct group members to complete the irrational thoughts assessment (see Appendix N) and the Informational Biases Scale (IBS) (Jefferson & Nicki, 2003). Have group members discuss the results in Dyads. Ask group members to discuss in their Dyads why they believe such thoughts are irrational and to add any additional irrational thoughts they have to the list (10 Minutes).

Debrief Exercise (10 Minutes): Ask group members to rejoin the larger group and discuss what was discussed in Dyads. Ask members what they learned by completing this activity.

BREAK: DURATION: 15 MINUTES

RECONSTRUCTING GAMBLING THOUGHTS EXERCISE: DURATION: 35 MINUTES

Introduce the exercise by explaining that it is not enough to identify irrational thoughts, but that they need to also reconstruct those particular thoughts. Not only do group members need to know where they are going, but also how to get there; therefore, showing members how to reconstruct thoughts is necessary (5 Minutes).

Review the Gambling Thought Record Handout (Appendix W) with group members and instruct them to write down what their most common irrational thoughts are. Then, instruct them to replace their irrational thoughts with an alternate more realistic thought (15 Minutes).

Debrief Exercise (15 Minutes): Ask group members to share with the larger group what irrational thoughts they reconstructed and what alternate thoughts they used. Ask members what they learned by completing the activity and what reactions they have about it.

CHECK OUT: DURATION: 5 MINUTES

Ask group members how the fifth session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the fifth session and note what will be covered next session. Remind group members of date, time, and place of next session. Also remind the group members that three more group sessions will occur before the group ends.

Assign Homework: Record and reconstruct thoughts about gambling in thought record.

SESSION EVALUATION: DURATION: 5 MINUTES

Hand out the session evaluation (see Appendix C) to each group member and inform them that their responses are anonymous, therefore; they do not need to put their name on the form. Instruct members to complete the form and when complete, they can flip it over in a designated location.

Session 5: Co-leader Debriefing

*Complete Session note for each group member (see Appendix E).
Discussion Questions:

1. How did the fifth session go; what went well and not so well?

_____
_____

2. What were your feelings, thoughts during the group regarding the group process?

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3. What were your impressions of group members?

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4. What personal feelings do I have regarding members?

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5. How did co-leadership go this session?

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6. What went well and not so well regarding co-leadership?

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7. What needs to change in order for co-leadership to run more smoothly?

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8. What changes would I like to make to improve my leadership skills for next session?

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9. Where do members appear to be regarding their stage in the group process?

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10. What do I need to do for next session to ensure group members remain safe?

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Lesson 6: Relapse Prevention

Duration: 2 hours

Objectives:

1. Teach skills to assist group members in preventing gambling relapse.
2. Group members will become familiar with relapse warning signs and triggers specific to gambling relapse (Vallejo & Amaro, 2009).
3. Group members will create a relapse prevention plan that considers their individual relapse warning signs and triggers.

Lesson 6 Exercises:

a. Identify Relapse Warning Signs Exercise
b. Create Action Plan Exercise
c. Behavioural Rehearsal Exercise

Handouts:

a. Warning Signs Handout (Appendix Y)
b. Gambling Recovery Signs Handout (Appendix M)

Introduction To Lesson 6: Duration: 15 Minutes

Recap Lesson 5 (5 Minutes)

Review Lesson 6 objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

Identify Relapse Warning Signs Exercise: Duration: 20 Minutes

Introduce the purpose of this activity to group members, which is to help them identify their relapse warning signs so that they can prevent relapse before it happens. Relapse occurs even before gambling behavior occurs. Review the Warning Signs Handout (Appendix Y) with group members (5 Minutes).

Have group members record on the handout their personal warning signs and what they will do to minimize the risk (5 Minutes).

Once group members have finished writing their warning signs and plan of action, ask them to share one of the warning signs and plan of action with the group (5 Minutes).

Debrief Exercise (5 Minutes): Ask members what they learned by completing this activity.

BREAK: DURATION: 15 MINUTES

CREATE ACTION PLAN EXERCISE: DURATION: 40 MINUTES

1. Review the Gambling Recovery Signs Handout (Appendix E) with group members and ask them which signs they currently have and which signs they need to incorporate into their recovery plan (10 Minutes).

2. Introduce this activity by explaining that the purpose of it is for group members to practice how they will cope with certain situations or triggers that they would usually cope with by gambling (Total time: 30 Minutes).

   On Flip Chart write the following question that group members will complete:

   1. What are 5 triggers (i.e., boredom, loneliness, stressors, etc.)?
   2. How can you cope effectively with these triggers?
   3. Who can be of personal and professional support in your recovery (List at least 5 each)?
   4. What will you replace your gambling with (i.e., hobbies, positive lifestyle changes, activities, etc.)?

   Split the members up into groups of two and instruct them to answer the latter questions. Get the members to designate someone from the group to write down the answers (provide markers and a large piece of flip chart paper to each group) and another person to present the answers in the larger group. Give participants 15 minutes to complete their answers. Go around from group to group occasionally in case members have questions. At around the 10 minute mark, remind group members that they have 5 more minutes to complete their answers.

   Once group members have completed their answers, instruct each group to stand up with the presenter as they present the group's answers (10 Minutes).

   Debrief Exercise (5 Minutes): Ask group members what they think of the activity.

Behavioural Rehearsal Exercise: Duration: 15 Minutes

Introduce this activity by explaining that the purpose of it is for group members to practice or rehearse (like acting) how they will cope with certain triggering situations.

Split the group members up into dyads and instruct them to come up with a triggering situation that they may come across. Once group members have selected a triggering situation, instruct them to act out the scenario. For instance, a triggering situation maybe a fight with a spouse; group members can act out how to behave appropriately in that situation (10 Minutes or 5 Minutes of rehearsal for each member of the dyad).

Debrief Exercise (5 Minutes): Ask group members to discuss their reactions.

Check Out: Duration: 5 Minutes

Ask group members how the sixth session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

Closing Remarks: Duration: 5 Minutes

Summarize what took place in the sixth session and note what will be covered next session. Remind group members of date, time, and place of the last two sessions.

Assign Homework: This week group members are to action at least one item on their recovery plan.

Session Evaluation: Duration: 5 Minutes

Hand out the session evaluation (see Appendix C) to each group member and inform them that their responses are anonymous, therefore; they do not need to put their name on the form. Instruct members to complete the form and when complete, they can flip it over in a designated location.

Session 6: Co-leader Debriefing

*Complete Session note for each group member (see Appendix E).
Discussion Questions:

1. How did the sixth session go; what went well and not so well?

_____
_____

2. What were your feelings, thoughts during the group regarding the group process?

_____
_____

3. What were your impressions of group members?

_____
_____

4. What personal feelings do I have regarding members?

_____
_____

5. How did co-leadership go this session?

_____
_____

6. What went well and not so well regarding co-leadership?

_____
_____

7. What needs to change in order for co-leadership to run more smoothly?

_____
_____

8. What changes would I like to make to improve my leadership skills for next session?

_____
_____

9. Where do members appear to be regarding their stage in the group process?

_____
_____

10. What do I need to do for next session to ensure group members remain safe?

_____
_____

Lesson 7: Apply Learning, Reflection & Feedback

Duration: 2 hours

Objectives:

1. Solidify group members' learning by reinforcing the application of learned skills.
2. To help group members reflect on their learning, how they have applied learning and to modify plans as needed.
3. To help prepare group members for group closure.

Lesson 7 Exercises:

a. Applying Learning Exercise
b. Reflection Exercise
c. Feedback Exercise

Handouts:

a. Since I quit gambling Handout (See Appendix L)

Introduction To Lesson 7: Duration: 15 Minutes

Recap Lesson 6 and review homework assigned last week (5 Minutes).

Review Lesson 7 objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

Applying Learning Exercise: Duration: 45 Minutes

The applying learning exercise involves reflecting on what has been learned, how they have already begun applying learning, revamping recovery plans, and how learning can be maintained.

1. Review each lesson briefly. Ask group members what they have learned from each lesson when doing the review of that lesson. Ask group members what they would like to improve on. Instruct them to make any needed changes to their recovery plans. Pass out pencils and ask group members to dig out their plan from last week. (25 Minutes).

2. Review the Since I quit gambling Handout (See Appendix L) and instruct group members to complete the questions (5 Minutes). Once group members have completed answering the questions on the handout, split the group up into Dyads and ask them to share their answers with each other (10 Minutes).

Debrief Exercise (5 Minutes): Ask group members how it was to engage in this activity.

BREAK: DURATION: 15 MINUTES

REFLECTION EXERCISE: DURATION: 30 MINUTES

Inform members that the purpose of this exercise is to reflect on what led to their involvement in the program as there is only one more week left and the potential challenges for continuing to apply learning once the group program ends.

Ask group members to discuss the following (20 Minutes):

1. What lead to your involvement in the program?
2. How have you achieved the goals you set out for yourself in Lesson 1, what goals are left to accomplish and how will you achieve it?
3. What are three things that you can take from the program and apply to your recovery?
4. What challenges do you think you will have in applying the tools learned in the program to your life and how will you overcome these challenges?

Encourage group members to continue daily practice even if it is for short periods of time and remind them to use the concept of 'beginner's mind', which is the idea that they can always activate tools learned at any time no matter how long it has been since they engaged in the practice.

Debrief Exercise (5 Minutes): Ask members to share how it was for them to reflect on what they have learned in the program.

Introduce Feedback Exercise as homework for next lesson: This exercise involves written feedback in a journal regarding their involvement in the program. The purpose of this homework is for group members to reflect on what they have learned and how they plan on transferring that learning to their lives (5 Minutes).

CHECK OUT: DURATION: 5 MINUTES

Ask group members how the second to last session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the seventh session and note what will be covered next session. Remind group members that the next session is the last one aside from the post-group session. Remind group members of date, time, and place of the last session.

Assign Homework: Reflection Journal

SESSION EVALUATION: DURATION: 5 MINUTES

Hand out the session evaluation (see Appendix C) to each group member and inform them that their responses are anonymous, therefore; they do not need to put their name on the form. Instruct members to complete the form and when complete, they can flip it over in a designated location.

Session 7: Co-leader Debriefing

*Complete Session note for each group member (see Appendix E).
Discussion Questions:

1. How did the seventh session go; what went well and not so well?

_____
_____

2. What were your feelings, thoughts during the group regarding the group process?

_____
_____

3. What were your impressions of group members?

_____
_____

4. What personal feelings do I have regarding members?

_____
_____

5. How did co-leadership go this session?

_____
_____

6. What went well and not so well regarding co-leadership?

_____
_____

7. What needs to change in order for co-leadership to run more smoothly?

_____
_____

8. What changes would I like to make to improve my leadership skills for next session?

_____
_____

9. Where do members appear to be regarding their stage in the group process?

_____
_____

10. What do I need to do for next session to ensure group members remain safe?

_____
_____

Lesson 8: Closure

Duration: 2 hours

Objectives:

1. Reflect on program learning
2. Reinforce and generalize learning to everyday situations
3. Deal with feelings of separation and termination
4. Deal with any unfinished business

Lesson 8 Exercises:

a. Review Feedback Journals
b. Process Group Closure
c. Reminder Object Exercise

Handouts:

a. Journal
b. Reminder Rocks

Introduction To Lesson 8: Duration: 15 Minutes

Recap Lesson 7 (5 Minutes)

Review Lesson 8 objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

Review Feedback Journals: Duration: 25 Minutes

As part of homework from last lesson, group members were instructed to complete a reflection journal. The purpose of this exercise is to review their reflection journals regarding what they have learned and how they plan on transferring that learning to their lives.

Ask members how they made out with their reflection journals, what they have learned, how they will transfer what they learned in group to their lives (20 Minutes).

Debrief Exercise (5 Minutes): Ask members what it was like to reflect on their learning.

PROCESS GROUP CLOSURE: DURATION: 25 MINUTES

To assist members in processing group closure discuss the following topics (20 Minutes).

1. What fears do you have about implementing your learning?
2. How are you feeling about separation and termination?
3. What unfinished business is there for us to deal with?
4. Give opportunity for members to give each other constructive feedback.
5. Reminder about confidentiality

Debrief Exercise (5 Minutes): Ask members what it was like to process group closure.

BREAK: DURATION: 15 MINUTES

REMINDER OBJECT EXERCISE: DURATION: 15 MINUTES

The final session involves using a symbolic reminder, such as a rock, of clients learned experience in the program, including the hard work they did, and as an intention to continue that learning. The session ends with a short meditation in which the symbolic reminder is explored (Barnhofer & Crane, 2009).

Pass around a collection of various rocks and instruct the group members to select a rock that they like. Ask them to notice how the rock feels in their hand, the rock's texture, the rock's colors and details, what thoughts and feelings come to mind as they are paying attention to the rock, and so on (5 Minutes).

Debrief Exercise (10 Minutes): Ask members to discuss the following questions. What did you notice (senses) as you were paying attention on purpose to the rock? How will you use this rock as a reminder of your learning?

CHECK OUT: DURATION: 15 MINUTES

Ask group members how the last session was for them and what is one last thing they would like to say to the group?

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the last session and note what will be covered in the post session. Remind group members of date, time, and place of the post session.

Assign Homework: Action three items on your recovery plan every week.

SESSION EVALUATION: DURATION: 5 MINUTES

Hand out the session evaluation (see Appendix C) to each group member and inform them that their responses are anonymous, therefore; they do not need to put their name on the form. Instruct members to complete the form and when complete, they can flip it over in a designated location.

Session 8: Co-leader Debriefing

*Complete Session note for each group member (see Appendix E).
Discussion Questions:

1. How did the last session go; what went well and not so well?

_____
_____

2. What were your feelings, thoughts during the group regarding the group process?

_____
_____

3. What were your impressions of group members?

_____
_____

4. What personal feelings do I have regarding members?

_____
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5. How did co-leadership go this session?

_____
_____

6. What went well and not so well regarding co-leadership?

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_____

7. What needs to change in order for co-leadership to run more smoothly?

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8. What changes would I like to make to improve my leadership skills for next session?

_____
_____

9. Where do members appear to be regarding their stage in the group process?

_____
_____

10. What do I need to do for next session to ensure group members remain safe?

_____
_____

Post Group Session

Duration: 1 hour 15 minutes

Note: This group session is to take place 2 weeks after the last lesson.

Objectives:

1. Assess the progress of goals.
2. Modify goals and recovery plans as needed.
3. Examine any challenges encountered and identify possible solutions.
4. Assess gambling thoughts and mindful awareness.

Exercises:

a. Ice Breaker Activity
b. Recovery Challenges Discussion
c. Assess and Modify Goals Exercise
d. Assess Gambling Thoughts and Mindful Awareness Exercise

Introduction To Post Group Session: Duration: 10 Minutes

Review Post Group objectives and schedule (5 Minutes): Have objectives and schedule prepared prior to group on Flip Chart.

Check in (5 Minutes): Ask members to describe in one word how they feel in the group at the moment.

Ice Breaker Activity: Duration: 15 Minutes

Explain to group members that the purpose of this activity is to reconnect as it has been a little while (2 weeks) since the last session.

Pass out markers, magazines, paper, tape, and scissors. Ask group members to draw or cut out a picture of one positive thing in their lives (5 minutes).

Debrief Exercise (10 Minutes): Ask group members to present their pictures. Once all members have presented, ask them what it was like to complete this activity.

ASSESS AND MODIFY GOALS EXERCISE: DURATION: 40 MINUTES

1. Recovery Challenges Discussion (15 Minutes)

   Ask each group member to share what challenges they have encountered in their recovery so far, what they have done to get through the challenges, and how they plan on dealing with challenges (10 Minutes).
   Debrief Exercise (5 Minutes): Ask group members what is was like to share challenges and to hear how others have challenges too.

2. Assess and Modify Goals Exercise (15 Minutes)

   Pass out paper and markers and ask group members to write one goal they achieved and how they did that since completing the program and one goal they hope to accomplish in the near future and how they plan to achieve it (5 Minutes). Ask each member to share their goals with the group (5 Minutes).

   Debrief Exercise (5 Minutes): Ask group members what is was like to share their goals and hear others share their goals.

3. Assess Gambling Thoughts and Mindful Awareness Exercise (10 Minutes)

   Pass out copies of the Informational Biases Scale (IBS) and the Mindful Attention Awareness Scale (MAAS) to see if group participants have lowered post-test scores compared to pre-test on the IBS (Jefferson & Nicki, 2003) and increased scores compared to pre-test scores on the MAAS (Brown, 2003). Instruct members to quickly fill out the questionnaires (5 Minutes).

   Debrief Exercise (5 Minutes): Ask group members to discuss their scores on the IBS and MAAS.

CHECK OUT: DURATION: 5 MINUTES

Ask group members how the post session was for them? If members are quiet, do a go around asking each member to indicate a one-word adjective that describes how they are feeling at the close of group. You can start the exercise as an example for the group.

CLOSING REMARKS: DURATION: 5 MINUTES

Summarize what took place in the post session. Note the resources in the area where they can access additional help if needed (i.e., Gambling Anonymous, individual addiction counselling, etc.), which can be given to clients in the form of a handout. Remind the group members one last time about the importance of confidentiality.

Appendix B

Group Counselling Informed Consent Form

Informed Consent for Group Counselling

Picture taken from Microsoft Word Clip Art

Background of Counsellor

Aby Cormier: I am an addictions counsellor; I have worked with adults and adolescents who have mental health and addiction issues in both residential treatment facilities and outpatient counselling offices. I have 8 years of experience in the helping profession having worked with at risk children and youth, persons with mental health issues, homeless youth and adults, and persons addicted to drugs, alcohol, and gambling. My counseling style is warm, empathetic, and collaborative, but at the same time I will challenge you to meet your desired goals. I have a Bachelor of Arts degree in Psychology from the University of New Brunswick and I am currently enrolled as a graduate student in the Master of Education, Applied Psychology program at the University of Lethbridge.

Counselling Process

The Canadian Group Psychotherapy Association defines group counselling as a collaborative process that occurs between the group members and group facilitators in order to achieve a desirable goal (Canadian Group Psychotherapy Foundation, 1995). Your efforts are important for the outcome of counselling to be successful. The group counsellors are not here to fix you, but rather act as advocates to help you reach a realistic goal. Some clients may experience strong emotions or distress as a result of sharing their personal experiences within a group setting, and that is a risk that all potential clients must be aware of.

Initial if in agreement and understanding of the contents of this section_____

Voluntary Nature of Counselling

If your group counsellors suggest a certain therapeutic intervention to assist in your healing process, you have the right for all potential risks and benefits of that intervention to be explained to you in a way that is understandable. If you do not agree to participate in that intervention, you have the right to refuse to participate in it. You also have the right to discontinue counselling at any time, but it is advisable to discuss this with your group counsellors first in order to prepare for the termination of counselling. You should make your group counsellors aware if you would like to leave a group session so that your leaving does not negatively impact the rest of the group members permanently. Your group counsellors may encourage you to explain your reasons for leaving with the group as well. You have the right to leave the group and/or not participate (Corey, Corey, & Callanan, 2007). Your group counsellors will discuss the group members' rights with the group several times throughout the group process to ensure the group is properly informed of them, and that the group is reaping the benefits of the counselling process. If you feel you are not reaping any benefits, then you and your group counsellors can discuss other options that may be more suited to you and your needs. These options are discussed later on in this consent form.

Initial if in agreement and understanding of the contents of this section_____

Risks and Benefits Associated with Group Counselling

Group counselling can benefit anyone, particularly those who have experienced trauma due to the safe environment in which to learn trauma survivors are not alone (agpa, 1995). To ensure the group will be as safe and productive as possible, potential group members go through a screening process to assure they are a good fit for group counselling. The following are some risks involved with group counselling: life disruption; client openness may reduce privacy; group pressure may occur although the group counsellors will be looking out for this in order to reduce unnecessary coercion; and confidentiality is not guaranteed due to the possibility that other group members may disclose information outside of the group. You are encouraged to keep other group members' sharing content to yourself. A common Alcoholics Anonymous saying, "What is said here, stays here" (Corey, Corey, & Callanan, 2007), explains the group membership agreement, which creates a safe exploration environment and mutual trust among group members.

Initial if in agreement and understanding of the contents of this section_____

Alternatives to Group Counselling

Group therapy is just one of the many choices in addiction and mental health treatment. Other choices include family counselling, individual counselling, 12-step programs, self-help books, hypnosis, nutritional consultation, and medication. As a consumer of addiction and mental health services, it is your right to ask about and be given information about these alternatives so you can decide which one is the best fit for you.

Initial if in agreement and understanding of the contents of this section_____

Length of Group Counselling

This group consists of 8 sessions, with each session last approximately 2 hours. Prior to the commencement of the group you will have a chance to meet the group counsellors in a pre-screening interview to determine if you are comfortable with them, and the session topics. If you are not, there is no pressure to join. Between the pre-screening interview and the group sessions, the group counsellors will facilitate a pre-group orientation in which you and the leaders will review the risks, benefits, and expectations of group counselling. You have the right to withdraw your group membership at that time if you do not feel comfortable continuing into the official session. Two weeks following the close of the group, all group members will meet for a post-session to share the progress of their healing with each other.

Initial if in agreement and understanding of the contents of this section_____

Medical Information

Group counsellors are not trained medical physicians, and therefore cannot prescribe medication. Medical concerns must be handled by competently trained medical professionals. If the medical information is pertinent to the counselling process, your group counsellor will provide you with a consent form that allows her to contact your medical professional and obtain only the necessary information. Any medical information that is shared with your counsellor will not become public knowledge for the group unless there is an urgent, specific need. For example, a group member with diabetes may need to use insulin during a group session, or a group member may suffer from epilepsy.

Initial if in agreement and understanding of the contents of this section_____

Confidentiality

Your group counsellors may be required to videotape some group sessions in order for their supervisor to review their work, and provide constructive criticism on how they can improve their skills. Your counsellors' supervisor will be the only person besides your counsellors that will watch the tape. The supervisor's role is to critique the counsellors' skills, not your story. After 14 days, the tape will be destroyed. You have the right at any time to change your mind regarding being recorded. The tape will be locked in a cabinet in the supervisor's office, and only the supervisor has the key to that cabinet.

What you tell your counsellor will be kept in confidence except for the following:

- Your counsellors may consult with their supervisor;
- If you disclose that you will harm yourself or others;
- If there is suspected child, elder, or dependent person abuse;
- If files are subpoenaed by the court;
- If you disclose crime details in which the statute of limitations has not expired; and
- Third parties (e.g., insurance company) may require information in your file for payment of services
- If group members disclose facts about other group members
- If the secretary needs to access your contact information to inform you of group cancellation.

If a group member is breaching confidentiality by disclosing information about other group members, that group member may be asked to leave the group to prevent further harm to the group (Corey, Corey, & Callanan, 2007).

Initial if in agreement and understanding of the contents of this section_____

Client's Right to Access Files

If clients want to see their counselling records they have a right to do so unless it is deemed to be harmful to them. For instance, information in files may be misinterpreted by untrained readers, and in that case it is best that your counsellors review its contents with you. Each member of the group will have their own separate file (Corey, Corey, & Callanan, 2007).

The only name contained in each member's file is her own so that in the event of a file being subpoenaed, only that particular client's file is viewed, rather than the files of every group member.

Initial if in agreement and understanding of the contents of this section_____

Transfer of Files and Services

In the event one of your counsellors suffers severe illness or incapacitation, and is no longer able to provide counselling, your file will automatically transfer to the remaining group counsellor and his or her supervisor. In addition, if one of the group counsellors is unable to attend a session due to illness or other unexpected circumstances, then the group will continue as planned with the remaining group counsellor.

Initial if in agreement and understanding of the contents of this section_____

Storage of Current Files

All of the files are stored on the group counsellors' office computer. The files are password protected, with the password being changed every 90 days. The computer itself is also password protected, with the password being changed every 90 days. The computer is physically locked to the desk and cannot be removed from the desk without keys to remove the locks. To further protect files, the office door is also locked and deadbolted anytime your group counsellor is away from the office. The main door to the office building also features locks and deadbolts that are locked after business hours. To prevent the loss of any files due to technological glitches or physical hazards like fire, all files are backed up onto a flash drive, which is kept in a safety deposit box offsite. Again, all files are password protected on the flash drive.

Initial if in agreement and understanding of the contents of this section_____

Storage of Closed Files

Within one week after counselling services have ended, your group counsellors will print your file from the computer and place it in a file folder. The file folder is then put in a fireproof safe offsite for 10 years. Your computerized file remains on the computer for those 10 years. If you return to counselling during those 10 years, then your group counsellor simply adds to the file on the computer until counselling is terminated again, and your group counsellor will print off the new record and add it to the file folder. If after 10 years from the last session date you have not returned, your group counsellor will shred the record in the file folder and replace it with a one-page summary of the services provided such as your name, length of treatment, general themes in treatment, and any referrals made to other services. The computerized file is deleted from the hard drive and flash drive as well.

Initial if in agreement and understanding of the contents of this section_____

Counselling Fees

There is no cost to participate in group as it is covered by your Alberta Health Care. If you must miss a session due to life emergencies such as sudden illness or accident, please let your group counsellors know as soon as possible so they can help the other group members understand your absence.

Initial if in agreement and understanding of the contents of this section_____

Release of Information

Information in your file may be released to persons only with your authorized written permission. Your group counsellors will discuss with you the need to collaborate with other professionals in the community you are involved with (i.e. medical doctors, previous counsellors) as that need arises. To consent to release information between your group counsellor and other professionals, you will be given a form to review with your group counsellor. No information can be released and shared between professionals until you agree with and sign the form.

Initial if in agreement and understanding of the contents of this section_____

Boundaries in Group Counselling

Your group counsellors will provide you with group counselling but, cannot provide you with individual counselling. Providing both services is considered a dual relationship (a relationship in which your counsellor has more than one role of authority with you), and dual relationships can be harmful to clients. If individual counselling would be beneficial to you, your group counsellors will refer you to a counsellor that is suitable to you. Your group counsellors will maintain healthy boundaries by fostering professional relationship rather than becoming personal friends, and by limiting incidental contact they have with you in the community. If your group counsellors see you in public, they will keep your identity private by not approaching you. If you decide to approach your group counsellors others may become aware that you are a client, since their profession may be widely known. Your group counsellors will only touch in ways that are comfortable with you and the entire group (such as a hand on an arm for support), and sexual relations of any sort are prohibited.

Initial if in agreement and understanding of the contents of this section_____

Communication

Most communication between group counsellors and group members takes place face-to-face in the office however; at times clients may need to place phone calls for various reasons. Because these types of communication are not necessarily secure, there can be no way of guaranteeing confidentiality. For example, if using a cell phone to communicate with a counsellor, you may be in a public place in which other people can overhear your conversation. Your group counsellors will only engage in these types of communication if you both can agree that the benefits outweigh the risks in your current circumstances.

Initial if in agreement and understanding of the contents of this section_____

Gift-giving

During the course of treatment, some clients feel inclined to present gifts to their counsellors in appreciation of the services they have received. However, some clients may not feel inclined to give gifts, but rather feel pressured into gift-giving if they realize other clients give gifts. The Canadian Code of Ethics for Psychologists encourages your counsellors to work in a spirit of fairness to all clients. To prevent any unethical behaviour on your counsellors' part, and nurture a spirit of fairness for all clients, your group counsellors ask that if you feel counselling has been successful then to share your positive experience with others so that more people may discover the benefits of healing through group counselling. If you still feel inclined to give thanks cards of appreciation are welcome. If you wish to give thanks in a monetary fashion, donations to a non-for-profit organization would be appropriate.

Initial if in agreement and understanding of the contents of this section_____

Honouring Diversity

This mindfulness group for gambling is open to all persons, over the age of 18 regardless of sexual orientation, culture, religion, relationship status, race, ethnicity, colour, national origin, or disability.

After reading the above document I voluntarily agree to begin group counselling services.

Print Name	Signature	Date
Client Name	Signature	Date
Counsellor Name	Signature	Date

Cormier, A., & Laycock, J. (2009). *Informed Consent for Group Counselling*. Unpublished manuscript.

Note: Permission was granted by Cormier and Laycock for users of this manual to modify the informed consent form as needed to use with their group members.

Appendix C

Client Feedback and Client Satisfaction Questionnaire

Client Feedback and Client Satisfaction Questionnaire

Your feedback is anonymous; therefore, please do not put your name on this form. Thank for your commitment in the group. We value your feedback, which will be used to make significant improvements to the program. Please complete this 5 minute questionnaire. **Instructions**: Please check off which answer applies most to the following statements.

1. I have been explained and understand confidentiality and its limits.
   (Complete for session 1 only).

0	1	2	3	4	5
Not at all satisfied	Not dissatisfied, but not satisfied	Very little satisfaction	Somewhat satisfied	Mostly satisfied	Very satisfied

2. I feel a sense of belonging with others in the group.

0	1	2	3	4	5
Not at all satisfied	Not dissatisfied, but not satisfied	Very little satisfaction	Somewhat satisfied	Mostly satisfied	Very satisfied

3. I am happy with the group leaders.

0	1	2	3	4	5
Not at all satisfied	Not dissatisfied, but not satisfied	Very little satisfaction	Somewhat satisfied	Mostly satisfied	Very satisfied

4. Group leaders have explained the material in an understandable way.

0	1	2	3	4	5
Not at all satisfied	Not dissatisfied, but not satisfied	Very little satisfaction	Somewhat satisfied	Mostly satisfied	Very satisfied

5. I feel confident that I can use what I am learning in the group in my life.

0	1	2	3	4	5
Not at all satisfied	Not dissatisfied, but not satisfied	Very little satisfaction	Somewhat satisfied	Mostly satisfied	Very satisfied

6. Challenges or barriers of attending the group have been addressed by group leaders.

0	1	2	3	4	5
Not at all satisfied	Not dissatisfied, but not satisfied	Very little satisfaction	Somewhat satisfied	Mostly satisfied	Very satisfied

7. I would recommend this group to others.

0	1	2	3	4	5
Not at all satisfied	Not dissatisfied, but not satisfied	Very little satisfaction	Somewhat satisfied	Mostly satisfied	Very satisfied

Appendix D

Group Membership Expectations Handout

Group Membership Expectations Handout

In order to create a safe and comfortable group environment, we have created a list of guidelines that will allow for such an environment. You will be given the chance to add to the following list. *** Further expectation may be added by group members**

1. Arrive to the group sober (i.e., if you arrive at group under the influence of alcohol or other drugs, you will not be permitted to attend group as this will inhibit your participation and may be triggering for other group members).

2. Please arrive 5 minutes prior to group to give yourself time to settle in.

3. Please turn off cell phones in order to minimize any distractions.

4. Please phone group leaders prior to group if you will be absent or late.

5. Please let the group leaders know if you need to leave the group for any reason (i.e., emergency bathroom break) while the group is in progress by raising your hand to get the leaders attention. If other members are aware of why you're leaving the group while it is in progress, they will not take your absence personally.

6. Please use appropriate non-offense communication.

7. Please refrain from romanticising or glorifying use (examples of this will be discussed in the first group session) as this may be triggering for group members; if this type of communication occurs the group leaders will interrupt you.

8. Mindfully attend to others when they are sharing (i.e., examples of mindfully attending to others will be explained in more detail during the first group session).

9. Respect the confidentiality of others (i.e., who is seen at group and what is shared at group, stays at group).

10. Avoid gossip of others in and out of group.

11. If conflict arises among members, this conflict should be dealt with in the group.

12. Only touch each other (i.e., hug, hand on back) if permission is granted.

13. What you get out of group is what you put into group.

*Ideas taken from Corey, Corey, and Corey (2010).

Appendix E

Group Client Session Note

Group Counselling Session Note

For The Group on Problem Gambling, Freedom from the Gambling Fog, developed by A. Cormier (2012)

- Client:_____
- Client ID: _____
- Date:_____
- Time of Group Session
- Session Number: Session Theme:
  (NOTE: For more information on today's group theme and the interventions used, including distributed handouts, please see the group manual)

Changes / Updates, as reported today by the client:

Today's observations of the client (as reported by the facilitators):

Additional comments about the client (e.g., assessment reports, homework issues, etc,):

Future issues and/or recommendations involving the client that should be noted for possible consideration:

Signatures of the facilitators:

*Note: Session note is modified from McBride (2010; 2012).

Appendix F

Marketing Poster

Picture taken from Microsoft Word Clip Art.

Description

This FREE group is a psychological support and educational group for those who have gambling issues to help them with the following.

1. Learn about problem gambling
2. Learn and enhance self-care skills
3. Learn how to recover from problem gambling

Sessions
Where:
When:

This group will teach a variety of strategies to help participants benefit from the program. Group members will be asked to contribute to the group through discussion and active participation. Members will be accepted with respect as to where they are on their journey of recovery. Group participation is voluntary.

What is heard in the group and who is seen at group stays at the group.

For inquiries and mandatory registration, please contact_____

Appendix G

Group Schedule Handout

GROUP SCHEDULE

Lesson 1: Group Introduction

Lesson 2: What is Problem Gambling?

Lesson 3: Introduction to Mindfulness

Lesson 4: Introduction to Mindfulness continued

Lesson 5: Introduction to CBT

Lesson 6: Relapse Prevention

Lesson 7: Apply Learning, Reflection & Feedback

Lesson 8: Closure

Appendix H

Problem Gambling Characteristics Handout

Problem Gambling Characteristics

Indicate whether the following statements apply to your gambling behaviour.

	YES	SOMEWHAT	NO
I spend large amounts of time gambling. This allows little time for family, friends or hobbies.	❍	❍	❍
I've begun to place larger, more frequent bets. Larger bets are necessary to get the same level of excitement.	❍	❍	❍
I return to gambling soon after a loss to try to recover the loss. "Chasing" my losses.	❍	❍	❍
I have growing debts. I am secretive or defensive about money, and may borrow money from family members or friends.	❍	❍	❍
I have pinned my hopes on the "big win." I believe the big win, rather than changing the gambling behaviour, will solve financial or other problems.	❍	❍	❍
I have made promises to cut back on gambling although I have been unable to reduce or stop gambling.	❍	❍	❍
I have covered up or lied about my gambling.	❍	❍	❍
If unable to gamble, I miss the thrill of the actions and may be bad-tempered, withdrawn, depressed or restless. During a winning steak, I am on a high.	❍	❍	❍
I have boasted about my winnings, or kept my losses a secret.	❍	❍	❍
I have missed special family occasions because of my gambling, e.g., birthdays, school activities, or other family gatherings.	❍	❍	❍
I found new places to gamble, both close to home and away. Holidays may be planned to places where gambling is available.	❍	❍	❍
I am unaware of time and surroundings; I am "spaced-out" when I gamble.	❍	❍	❍

Handout taken from the Counsellors' Resource Toolbox on the Internal Alberta Health Services Website.

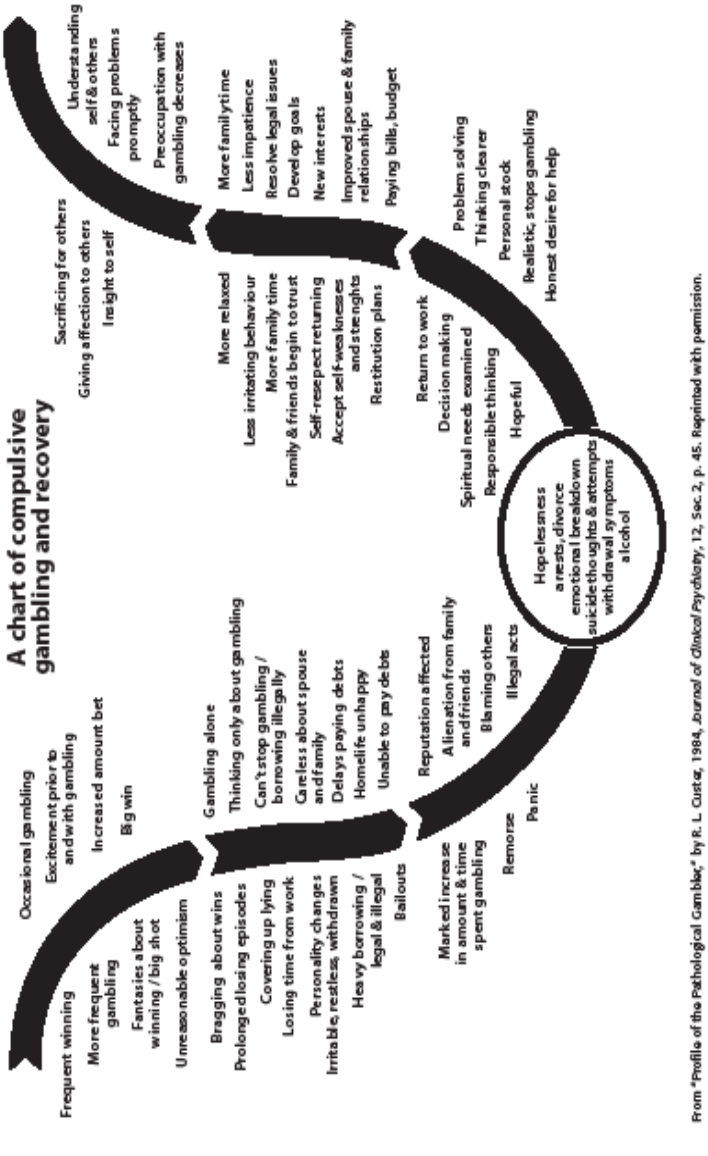
Appendix I

Phases of Gambling Addiction and Recovery Handout

HANDOUT

Phases of problem gambling and recovery

Serious problem gambling is also sometimes called compulsive gambling. The following chart shows how gambling problems can develop and how people recover from these problems.



From "Profile of the Pathological Gambler," by R. L. Custer, 1984, *Journal of Clinical Psychiatry*, 12, Sec. 2, p. 45. Reprinted with permission.

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Handout taken from the Counsellors' Resource Toolbox on the Internal Alberta Health Services Website.

Appendix J

Stages of Change Handout

Stages of Change

Precontemplation: No change is desired and denial is present.

Contemplation:. Ambivalence is present as change is both considered and resisted.

Preparation: The problem is realized and an action plan is being developed for change.

Action: Steps are taken to action the plan for change.

Maintenance: Change has occurred and progress continues to be made (6 months abstinence).

Questions for Reflection

What stage are you in currently and how do you know this is the stage you are at?

How have you moved from one stage to another?

What steps do you need to take to progress to the next stage?

Information on handout regarding the stages of change modified from

Miller, W. M., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. NY: The Guildford Press.

Appendix K

"Where am I with my gambling problem?" Handout

Where Am I with My Gambling Problem?

Check the box below that best represents how you feel about your gambling:

- ❍ Denial/minimizing ("It's not that bad." "What's the big deal?")
- ❍ Bargaining ("I'll only go on Thursdays." "I'll pay you back...")
- ❍ Hope (genuine hopefulness, "I hope I'll win this time.")
- ❍ Sadness (reality sets in, "I've made some bad mistakes.")
- ❍ Guilt/Shame ("How could I have done this again?")
- ❍ Anger (general or specific)
- ❍ Acceptance ("I need help. I can't gamble again."
- ❍ Optimism ("I'm feeling stronger all the time. I'm starting to feel good again.")
- ❍ Contentment ("I can relax a bit more. Although I can't gamble, I have other ways of coping.")

Handout taken from the Counsellors' Resource Toolbox on the Internal Alberta Health Services Website.

Appendix L

Since I quit Gambling Handout

Since I've Quit Gambling…

Complete the following statements in the space provided.
Revisit your answers over the course of the treatment program and add to your answers with insights you have gained.

1. Since I've quit gambling, the best thing that has happened to me is:

2. The most difficult problem I've had to face, since I've quit gambling, is:

3. Even though I'm not gambling anymore, I still have to understand that:

4. The best thing about not gambling anymore is:

Handout taken from Alberta Health Services Website with permission to use for therapy purposes.

Appendix M

Signs of Recovery from Problem Gambling Handout

Signs of Recovery from Problem Gambling

1. Admits problem.
2. Recognizes how behaviour affects others.
3. Returns to work (if hospitalized or unemployed).
4. Establishes and maintains budget.
5. Makes decisions regarding who will handle money in the family.
6. Expresses concern for family appropriately. Develops empathy and sensitivity.
7. Develops problem-solving skills.
8. Fewer crises.
9. Establishes and maintains a savings plan.
10. Learns to express anger appropriately.
11. Increases family closeness.
12. Issues of gambling appear less frequently and often genuine problems emerge as a focus—not the gambling.
13. Has positive self-esteem and self-acceptance.
14. Tolerates tension and the development of stress reduction techniques.
15. Develops appropriate leisure activities as a substitute for the preoccupation with gambling.

Appendix N

Irrational Thoughts about Gambling Handout

WORKSHEET

Irrational thoughts about gambling

Most people with a gambling problem know at some level that they will never win back all the money they have lost, yet they continue to "chase their losses." In other words, they rationally know the truth but when they get into the situation, their thoughts and ideas become irrational. Irrational thoughts tend to be based on fears, desires, myths, superstitions or fantasies. In contrast, rational thoughts are reasonable, realistic and based on facts.

Check off which irrational thoughts you have had, either when you are gambling or between gambling sessions. Take a few moments to reflect on why each of these thoughts is irrational.

- ❑ Gambling is an easy way to earn money.
- ❑ Gambling is healthy recreation for me.
- ❑ My gambling is under control.
- ❑ I can win it back.
- ❑ I'm smart; I have a system to beat the odds.
- ❑ Someday I'll score a really big win.
- ❑ Gambling will solve my problems.
- ❑ Gambling makes me feel better.
- ❑ I will pay it back.
- ❑ Stealing to gamble isn't really stealing.
- ❑ The more money I have to gamble with, the better my chances of winning.
- ❑ I'm a lucky person.
- ❑ I can't stop.
- ❑ I can stop anytime.
- ❑ I'm due for a big win.
- ❑ Gambling helps me relax.
- ❑ I can't afford to pay for treatment or take time off work to get help.
- ❑ I have to make as much money as I can, as quickly as I can.
- ❑ I always win.
- ❑ Even if I only have a few bucks, I'm better off taking a chance.
- ❑ This is the last time I will gamble.

Other irrational thoughts I have had:

*_____

*_____

*_____

Handout taken from Alberta Health Services Website with permission to use for therapy purposes.

Appendix O

Mindfulness Handout

Permission has been granted for the copyrighted materials to be used for therapy purposes (see note at the bottom of handout).

Mindfulness

Jon Kabat-Zinn

What is Mindfulness?

Mindfulness is an ancient eastern practice which is very relevant for our lives today. Mindfulness is a very simple concept. Mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgementally.

Mindfulness does not conflict with any beliefs or traditions, whether religious, cultural or scientific. It is simply a practical way to notice thoughts, physical sensations, sights, sounds, smells - anything we might not normally notice. The actual skills might be simple, but because it is so different to how our minds normally behave, it takes a lot of practice.

We might go out into the garden and as we look around, we might think "That grass really needs cutting, and that vegetable patch looks very untidy". A young child on the other hand, will call over excitedly, "Hey - come and look at this ant!"

Mindfulness can simply be noticing what we don't normally notice, because our heads are too busy in the future or in the past - thinking about what we need to do, or going over what we have done.

Mindfulness might simply be described as choosing and learning to control our focus of attention.

Automatic Pilot

In a car, we can sometimes drive for miles on "automatic pilot", without really being aware of what we are doing. In the same way, we may not be really "present", moment-by-moment, for much of our lives: We can often be "miles away" without knowing it.

On automatic pilot, we are more likely to have our "buttons pressed": Events around us and thoughts, feelings and sensations (of which we may be only dimly aware) can trigger old habits of thinking that are often unhelpful and may lead to worsening mood.

By becoming more aware of our thoughts, feelings, and body sensations, from moment to moment, we give ourselves the possibility of greater freedom and choice; we do not have to go into the same old "mental ruts" that may have caused problems in the past.

Mindful Activity

If we wash the dishes each evening, we might tend to be 'in our heads' as we're washing up, thinking about what we have to do, what we've done earlier in the day, worrying about future events, or regretful thoughts about the past. Again, a young child might see things differently, "Listen to those bubbles! They're fun!"

Washing up or another routine activity can become a routine (practice of) mindful activity for us. We might notice the temperature of the water and how it feels on the skin, the texture of the bubbles on the skin, and yes, we might hear the bubbles as they softly pop. The sounds of the water as we take out and put dishes into the water. The smoothness of the plates, and the texture of the sponge. Just noticing what we might not normally notice.

A mindful walk brings new pleasures. Walking is something most of us do at some time during the day. We can practice, even if only for a couple of minutes at a time, mindful walking. Rather than be "in our heads", we can look around and notice what we see, hear, sense. We might notice the sensations in our own body just through the act of walking. Noticing the sensations and movement of our feet, legs, arms, head and body as we take each step. Noticing our breathing. Thoughts will continuously intrude, but we can just notice them, and then bring our attention back to our walking.

The more we practice, perhaps the more (initially at least) we will notice those thoughts intruding, and that's ok. The only aim of mindful activity is to bring our attention back to the activity continually, noticing those sensations, from outside and within us.

Mindful Breathing

The primary focus in Mindfulness Meditation is the breathing. However, the primary goal is a calm, non-judging awareness, allowing thoughts and feelings to come and go without getting caught up in them. This creates calmness and acceptance.

- Sit comfortably, with your eyes closed and your spine reasonably straight.
- Direct your attention to your breathing.
- When thoughts, emotions, physical feelings or external sounds occur, simply accept them, giving them the space to come and go without judging or getting involved with them.
- When you notice that your attention has drifted off and is becoming caught up in thoughts or feelings, simply note that the attention has drifted, and then gently bring the attention back to your breathing.

It's ok and natural for thoughts to arise, and for your attention to follow them. No matter how many times this happens, just keep bringing your attention back to your breathing.

Breathing Meditation 1 (Kabat-Zinn 1996)

Assume a comfortable posture lying on your back or sitting. If you are sitting, keep the spine straight and let your shoulders drop.

Close your eyes if it feels comfortable.

Bring your attention to your belly, feeling it rise or expand gently on the in-breath and fall or recede on the out-breath.

Keep your focus on the breathing, 'being with' each in-breath for its full duration and with each out-breath for its full duration, as if you were riding the waves of your own breathing.

Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.

If your mind wanders away from the breath a thousand times, then your job is simply to bring it back to the breath every time, no matter what it becomes preoccupied with.

Practice this exercise for fifteen minutes at a convenient time every day, whether you feel like it or not, for one week and see how it feels to incorporate a disciplined meditation practice into your life. Be aware of how it feels to spend some time each day just being with your breath without having to *do* anything.

Breathing Meditation 2 (Kabat-Zinn 1996)

- Tune into your breathing at different times during the day, feeling the belly go through one or two risings and fallings.
- Become aware of your thoughts and feelings at these moments, just observing them without judging them or yourself.
- At the same time, be aware of any changes in the way you are seeing things and feeling about yourself.

Using mindfulness to cope with negative experiences (thoughts, feelings, events)

As we become more practised at using mindfulness for breathing, body sensations and routine daily activities, so we can then learn to be mindful of our thoughts and feelings, to become observers, and then more accepting of them. This results in less distressing feelings, and increases our ability to enjoy our lives.

With mindfulness, even the most disturbing sensations, feelings, thoughts, and experiences, can be viewed from a wider perspective as passing events in the mind, rather than as "us", or as being necessarily true. (Brantley 2003)

When we are more practiced in using mindfulness, we can use it even in times of intense distress, by becoming mindful of the actual experience as an observer, using mindful breathing and focussing our attention on the breathing, listening to the distressing thoughts mindfully, recognising them as merely thoughts, breathing with them, allowing them to happen without believing them or arguing with them. If thoughts are too strong or loud, then we can move our attention to our breath, the body, or to sounds around us.

Jon Kabat-Zinn uses the example of waves to help explain mindfulness.

Think of your mind as the surface of a lake or an ocean. There are always waves on the water, sometimes big, sometimes small, sometimes almost imperceptible. The water's waves are churned up by winds, which come and go and vary in direction and intensity, just as do the winds of stress and change in our lives, which stir up waves in our mind. It's possible to find shelter from much of the wind that agitates the mind. Whatever we might do to prevent them, the winds of life and of the mind will blow.

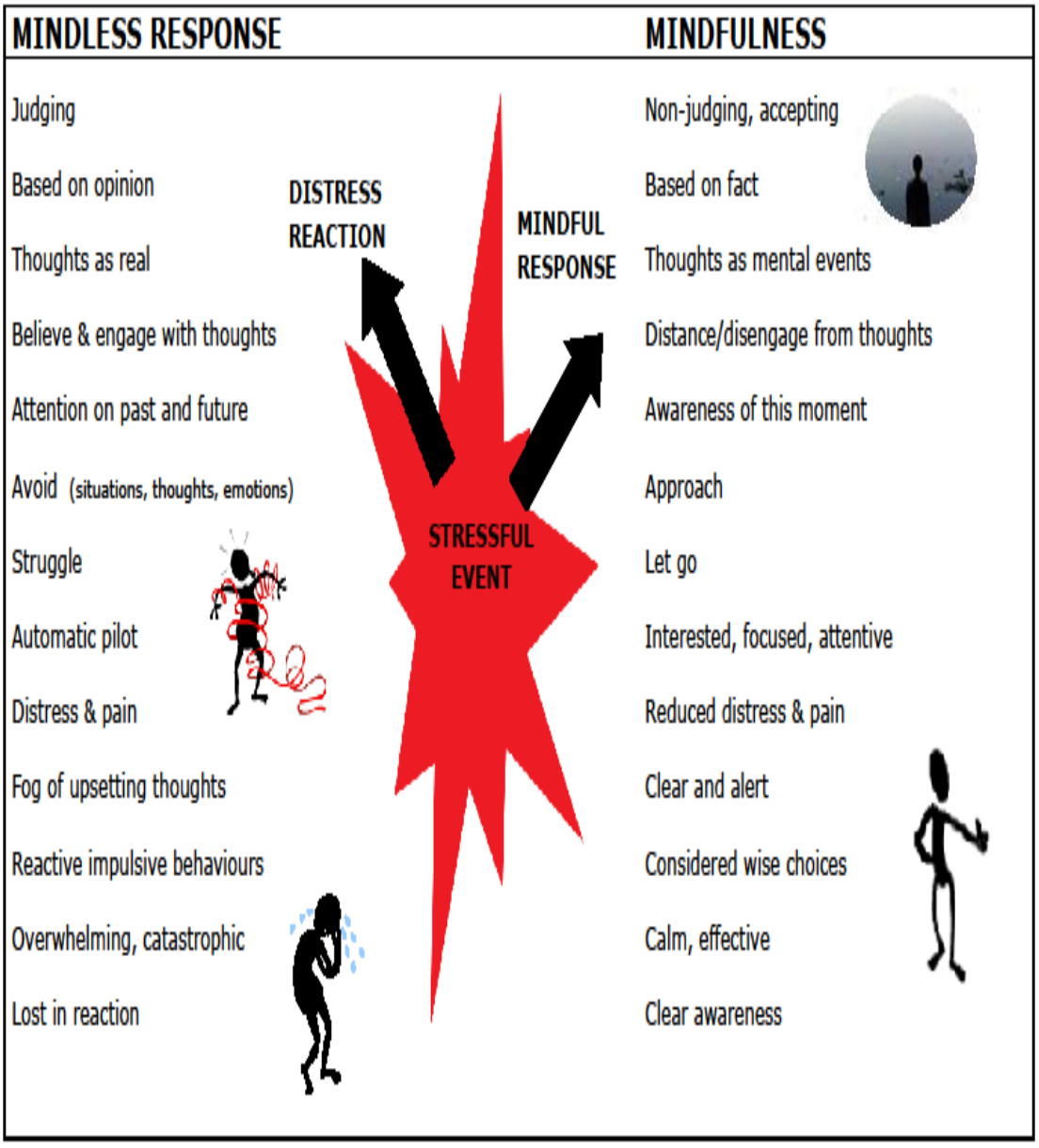
"You can't stop the waves, but you can learn to surf" (Kabat-Zinn 2004)

Appendix P

Mindfulness Rationale Handout

Permission has been granted for the copyrighted materials to be used for therapy purposes (see note at the bottom of handout).

Why Mindfulness?



- Consider the most distress you have experienced or are ever likely to experience. Is that time in the past? Is it perhaps in the future?
- Right now, at this very moment, are you the most distressed you have ever been or are likely to be?
    - If not, then perhaps that's a good reason to learn to be mindful - to put our attention to this very moment.

Appendix Q

The Visitor Handout

Permission has been granted for the copyrighted materials to be used for therapy purposes (see note at the bottom of handout).

The Visitor

This exercise helps to develop a mindful awareness of the environment, of the body, of the breath, and of thoughts and emotions. You can practice the exercise as a whole, or in parts – using any part of the exercise.

The Environment

As you're walking, or just sitting quietly somewhere, start to notice things as though you were a visitor to this place. As you look around you, notice sights, sounds and smells as though you had never seen, heard or smelled them before. You can imagine you are a visitor from another area or culture, or from a different species or even planet. Seeing or hearing things for the first time, from a completely different perspective. Spend a little time just looking and listening and noticing.

The Body

When 'Dr Who' regenerates, he immediately checks out his new body. As a newcomer or visitor, start to imagine being in your body for the first time. Notice what that feels like – what bodily sensations do you notice? How does it feel to move around, stretching those muscles, standing up or sitting down. What do those hands feel like as you move them about, stretching and wiggling those fingers, clenching those fists? As you start to walk, how is that? What do you notice about your legs – upper legs, feet and toes? Move your head around and notice what you neck and shoulders feel like. Bend, stretch and move about. What are those physical sensations? Spend a little time just noticing those bodily sensations, and imagine taking your body for its first ever walk, or any everyday activity.

The Breath

What would you, as a new awareness or visitor to this new body, notice about the sensations of breathing, as you breathe in, then out? Notice the sensations in the abdomen, the chest, the throat, the mouth and nose. You can notice how your attention wanders, as thoughts come in, sometimes crowding in, and your attention can follow those thoughts. Just notice as your attention wanders, then gently bring your focus back to your breath. Minds do wander, thoughts will come and thoughts will go, that is the nature of the human mind. As a visitor, you can stand back, notice those thoughts, feelings, sounds and sensations, and keep bringing your attention back to your breath.

Thoughts and Emotions

Then you can start to notice, as a visitor, the thoughts and images, feelings and emotions that come and go, in this your new body and mind. You're brand new to this body and mind, and there are no expectations for you to react to any thought, image or emotion – you can just notice them, and not respond. As a visitor, you can notice that they are just words and images, sensations, and feelings. Merely notice them as you would as a new visitor to this body and mind. Words and images, sensations and feelings: they come, and they go, and that's okay, because that's just what the human mind does.

Appendix R

Mindfulness of Feelings Handout

Permission has been granted for the copyrighted materials to be used for therapy purposes (see note at the bottom of handout).

Mindfulness of Emotions

We often start to learn mindfulness skills by focusing our attention on our breath, our bodies, the environment or activities. Being mindful of emotions helps us to stand back from the emotion, understand it, not to fear it or struggle against it, and it can have the added benefit of reducing the distress (although the aim is to learn to accept the experience, rather than lessen the distress).

Set aside a few minutes when you can be quiet and won't be disturbed.

Start by bringing your attention to your breath. Notice your breathing as you slowly breathe in and out, perhaps imagining you have a balloon in your belly, noticing the sensations in your belly as the balloon inflates on the in-breath, and deflates on the out-breath.

Notice the feelings, and what it feels like.

Name the emotion:

- What is it?
- What word best describes what you are feeling?
- Angry, sad, anxious, irritated, scared, frustrated…

Accept the emotion. It's a normal body reaction. It can be helpful to understand how it came about – what it was, the set of circumstances that contributed to you feeling this way. Don't condone or judge the emotion. Simply let it move through you without resisting it, struggling against it, or encouraging it.

Investigate the emotion.

- How intensely do you feel it?
- How are you breathing?
- What are you feeling in your body? Where do you feel it?
- What's your posture like when you feel this emotion?
- Where do you notice muscle tension?
- What's your facial expression? What does your face feel like?
- Is anything changing? (nature, position, intensity)

What thoughts or judgements do you notice? Just notice those thoughts. Allow them to come into your mind, and allow them to pass. Any time you find that you're engaging with the thoughts – judging them or yourself for having them, believing them, struggling against them, just notice, and bring your attention back to your breathing, and to the physical sensations of the emotion.

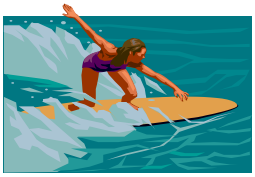
If any other emotions come up, if anything changes, simply notice and repeat the steps above. Just notice that the feelings change over time.

As you become more practised, you can use this mindfulness technique when you feel more intense emotion.

Appendix S

Mindfulness Visuals Handout

Mindfulness Meditation Script:



1. Urge surfing

When you sit with your back supported in a chair, sooner or later you may notice some sense of discomfort arising, such as restlessness or an itch. Along with these sensations there will be an urge to move. This is an opportunity to practice urge surfing, so we can notice the difficult sensations that go with this and the thoughts that arise. Instead of acting in our normal way of trying to get rid of this unpleasant feeling, we become curious. We become like natural scientists seeing a strange plant or animal for the first time. We try to describe what we are observing as closely as possible. In this way we replace an aversion with curiosity. So notice any physical sensation that goes with the urge as precisely as possible (http://www.mindfulness.org.au/URGE%20SURFING.htm).

2. Ocean & Wind:

Imagine that urges are like ocean waves that arrive at shore and subside. They are small when they start, will grow in size then, will break up and dissipate. You can also think of your mind as the surface of the ocean. There are always waves on the water, sometimes big, sometimes small, and sometimes almost faint. The water's waves are churned up by winds, which come and go and vary in direction and intensity, just as do the winds of stress and change in our lives, which stir up waves in our mind. It's possible to find shelter from much of the wind that agitates the mind. Whatever we might do to prevent them, the winds of life and of the mind will blow and this is normal (http://www.getselfhelp.co.uk/docs/Mindfulness.pdf).

3. The Visitor:

The Environment
As you're sitting here quietly, start to notice things as though you were a visitor to this place. As you look around you, notice sights, sounds and smells as though you had never seen, heard or smelled them before. You can imagine you are a visitor from another area or culture, or from a different species or even planet. Seeing or hearing things for the first time, from a completely different perspective. Spend a little time just looking and listening and noticing.

Thoughts and Emotions
Then you can start to notice, as a visitor, the thoughts and images, feelings and emotions that come and go, in this your new body and mind. You're brand new to this body and mind, and there are no expectations for you to react to any thought, image or emotion – you can just notice them, and not respond. As a visitor, you can notice that they are just words and images, sensations, and feelings. Merely notice them as you would as a new visitor to this body and mind. Words and images, sensations and feelings: they come, and they go, and that's okay, because that's just what the human mind does (http://www.getselfhelp.co.uk/docs/TheVisitor.pdf).

4. River:

Imagine you're sitting on the bank of a river. Notice your thoughts, feelings, and sensations floating down the river. If you notice yourself floating down the river with your experience, you can simply swim back to the side of the bank as you watch your thoughts, feelings, and sensations float on by.

5. Clouds:

Imagine your thoughts, feelings, or sensations floating by you in the sky on clouds; they come and they go as you watch from the ground.

6. Kite:

You may choose to imagine that your thoughts, feelings, and sensations are attached to the end of a kite that you are flying. You're in control of the kite as you steer it from the ground. The wind may come and blow the kite around, but you're unaffected as you watch from the ground.

7. Bubbles:

Imagine your thoughts, feelings, or sensations floating by you in bubbles in the air or on the surface of water; they come, they go, and float on by.

8. Train:

Imagine your thoughts, feelings, or sensations riding a train going by you on the tracks. You're on the side of the road watching your experience go by you on the train.

You can even create your own visuals that work you.

All pictures taken from Microsoft Word Clip Art

Appendix T

Team Building Exercise

Past, Present, and Future Activity

Picture taken from Microsoft Work Clip Art

Rationale

The purpose of this activity is to increase a sense of belonging among group members and for them to get to know each other more by sharing an aspect of their lives.

Objectives

The main objective of the activity is not for members to create beautiful art (explain that to the group members), but to use a visual representation to share one aspect of their lives (past, present, or future) with other group members.

Procedure

Beginning: Explain the purpose of the activity. Instruct members to illustrate on paper, either by drawing or choosing a magazine cut out, one thing about their past, present, or future that they would like to share with the group.

Activity: Group members are to sit at tables (use clip boards if tables are unavailable) to work individually on the activity. Distribute materials (see supplies). After 5 minutes, group members re-join the group to share their picture. If the group is large enough, you may want to split the group up in pairs.

Debrief: Ask each member to share their picture in the bigger group. Debrief the activity with group members. One debriefing question to ask members is, "What was it like for you to engage in this activity?"

Room needs

The room should be big enough for members to spread out to work on the activity and have working surfaces, such as tables (clip boards if tables are unavailable) and chairs for sitting. Ensure there is a clock in the room for time keeping.

SuppliesMagazines, paper, glue stick/tape, scissors, and markers and crayons.

Timing

Total time needed for the activity is 15 minutes: 5 minutes for creating pictures, 5 minutes for the presentation of group members' pictures, and 5 minutes for debriefing the activity.

Modifications: The activity may be modified to different ages, cultures, disabilities, and settings.

Cormier, A. (2011). *Team Building: Past, Present, or Future Activity*. Unpublished manuscript

Appendix U

S.M.A.R.T Goals Handout

S.M.A.R.T Goals

Specific

Measurable

Attainable

Realistic

Timely

Specific: A specific goal has a much greater chance of being accomplished than a general goal. The following six "W" questions will help you set a specific goal:

Who: Who is involved?

What: What do I want to accomplish?

Where: Identify a location.

When: Establish a time frame.

Which: Identify requirements and constraints.

Why: Specific reasons, purpose or benefits of accomplishing the goal.

EXAMPLE: A general goal would be, "Be in recovery from gambling." But a specific goal would say, "Join a support group and attend once a week."

Measurable - Establish concrete criteria for measuring progress toward the attainment of each goal you set.

When you measure your progress, you stay on track, reach your target dates, and experience the excitement of achievement that encourages you to continue effort required to reach your goal.

To determine if your goal is measurable, ask questions such as……

How much? How many? How will I know when it is accomplished?

Attainable – When you identify goals that are most important to you, you begin to figure out ways you can make them come true. You develop the attitudes, abilities, skills, and financial capacity to reach them. You begin seeing previously overlooked opportunities to bring yourself closer to the achievement of your goals.

You can attain most any goal you set when you plan your steps wisely and establish a time frame that allows you to carry out those steps. Goals that may have seemed far away and out of reach eventually move closer and become attainable, not because your goals shrink, but because you grow and expand to match them. When you list your goals you build your self-image. You see yourself as worthy of these goals, and develop the traits and personality that allow you to possess them.

Realistic- To be realistic, a goal must represent an objective toward which you are both *willing* and *able* to work. A goal can be both high and realistic; you are the only one who can decide just how high your goal should be. But be sure that every goal represents substantial progress.

A high goal is frequently easier to reach than a low one because a low goal exerts low motivational force. Some of the hardest jobs you ever accomplished actually seem easy simply because they were a labor of love.

Timely- A goal should be grounded within a time frame. With no time frame tied to it there's no sense of urgency. If you want to quit gambling, when do you want to quit by? "Someday" won't work. But if you anchor it within a timeframe, "by May 1st", then you've set your unconscious mind into motion to begin working on the goal.
Your goal is probably realistic if you truly *believe* that it can be accomplished. Additional ways to know if your goal is realistic is to determine if you have accomplished anything similar in the past or ask yourself what conditions would have to exist to accomplish this goal.

Information on this handout is modified from http://topachievement.com/smart.html

Appendix V

Therapy Goals Handout

Permission has been granted for the copyrighted materials to be used for therapy purposes (see note at the bottom of handout).

Therapy Goals

Name:	Number/DoB:	Date:

Goal 1:
What steps can I make towards achieving this goal?
On a scale of 0 – 10 with 0 being totally not achieved and 10 being totally achieved, how far along the scale am I now, with regard to this goal? 0 1 2 3 4 5 6 7 8 9 10 Not at all achieved — Moderately achieved — Totally achieved

Goal 2:
What steps can I make towards achieving this goal?
On a scale of 0 – 10 with 0 being totally not achieved and 10 being totally achieved, how far along the scale am I now, with regard to this goal? 0 1 2 3 4 5 6 7 8 9 10 Not at all achieved — Moderately achieved — Totally achieved

Goal 3:
What steps can I make towards achieving this goal?
On a scale of 0 – 10 with 0 being totally not achieved and 10 being totally achieved, how far along the scale am I now, with regard to this goal? 0 1 2 3 4 5 6 7 8 9 10 Not at all achieved — Moderately achieved — Totally achieved

Appendix W

Gambling Thought Record Handout

Permission has been granted for the copyrighted materials to be used for therapy purposes (see note at the bottom of handout).

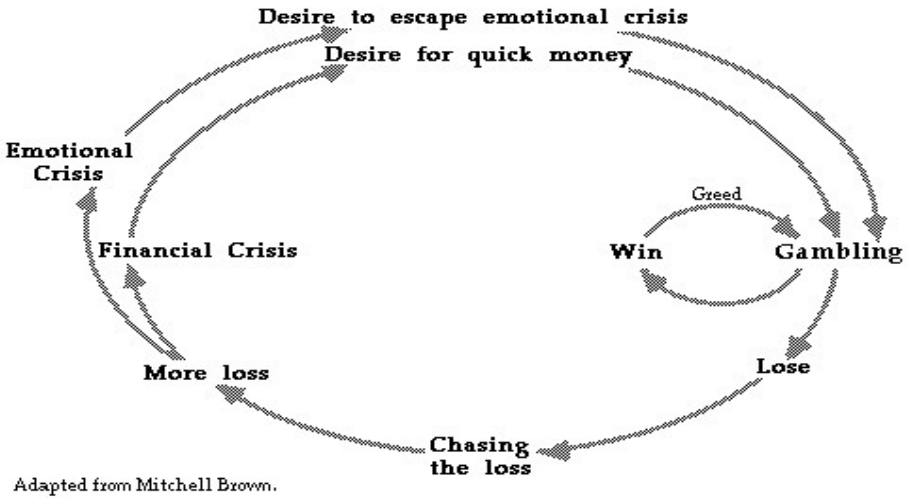
Thought Record Sheet – 7 column

Situation / Trigger	Feelings Emotions – (Rate 0 – 100%) Body sensations	Unhelpful Thoughts / Images	Facts that <u>support</u> the unhelpful thought	Facts that provide evidence <u>against</u> the unhelpful thought	Alternative, more realistic and balanced perspective	Outcome Re-rate emotion
What happened? Where? When? Who with? How?	*What emotion did I feel at that time? What else? How intense was it?* *What did I notice in my body? Where did I feel it?*	*What went through my mind? What disturbed me? What did those houghts/images/memories mean to me, or say about me or the situation? What am I responding to? What 'button' is this pressing for me? What would be the worst thing about that, or that could happen?*	*What are the facts? What facts do I have that the unhelpful thought/s are totally true?*	*What facts do I have that the unhelpful thought/s are NOT totally true? Is it possible that this is opinion, rather than fact? What have others said about this?*	*STOPP! Take a breath....* *What would someone else say about this situation? What's the bigger picture? Is there another way of seeing it? What advice would I give someone else? Is my reaction in proportion to the actual event? Is this really as important as it seems?*	*What am I feeling now? (0-100%)* *What could I do differently? What would be more effective?* *Do what works! Act wisely. What will be most helpful for me or the situation? What will the consequences be?*

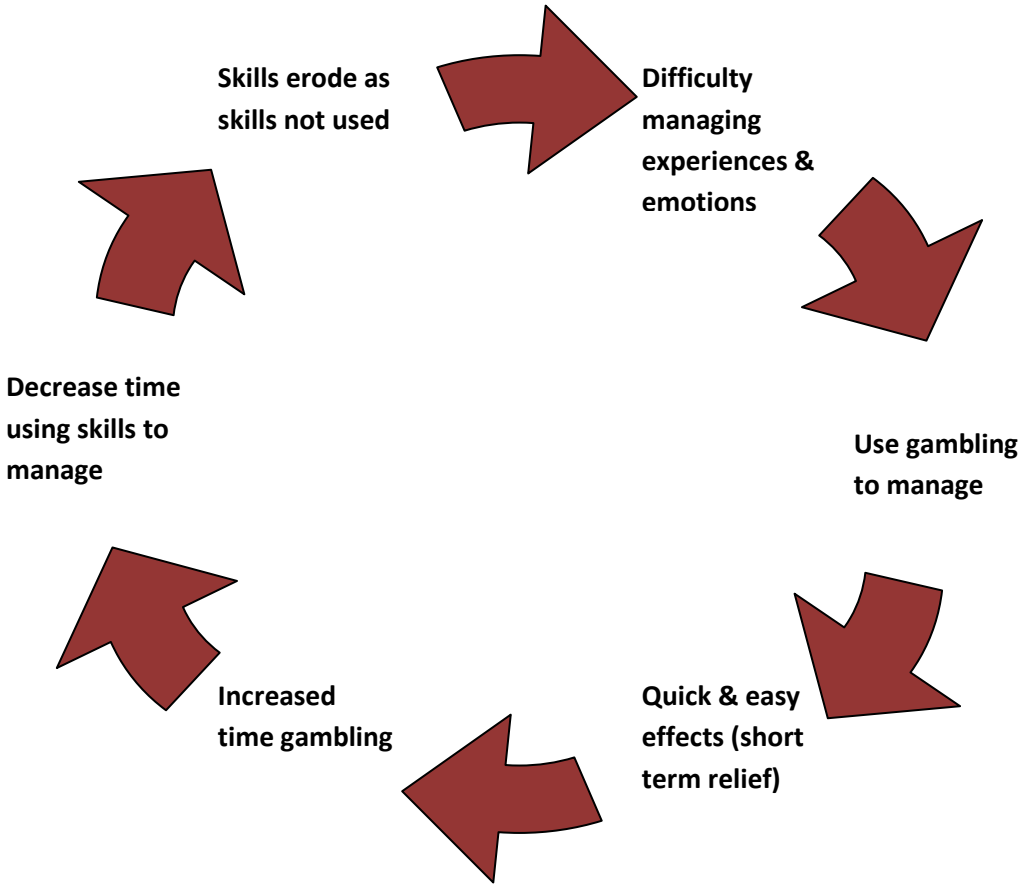
Appendix X

Gambling Cycle Handout

The Cycle of Problem Gambling



Adapted from Mitchell Brown.



The Cycle of Problem Gambling

There is a well-known and recognisable cycle/pattern found in problem gambling. People with a gambling problem usually experience the things that are outlined in the cycle.

The gambling cycle will continue until some significant commitment to change occurs.

Desire to Escape Emotional Crisis

To escape from painful emotional states. Example: resentment, anger, stress, anxiety, boredom, depression, loneliness, self-pity, or any other uncomfortable feeling.
To escape to a change of mood (though short lived - esp. with scratch tickets), to a world of your own, where you can withdraw into yourself. To numb-out and time-out, to fantasise, or whatever a person wants out of gambling.
Problem gamblers have chosen to use gambling as a coping strategy - as a way of dealing with unpleasant emotional states.

Desire for Quick Money

Hopes and beliefs in 'winning' / of getting quick money - a quick fix. The desire to gamble as a way to solve financial problems: 'A big win, now, will solve all my problems'. This is relying on false hope:
To improve one's worth. To prove one's worth.
Paying attention only to past wins and not considering the losses or possible negative consequences. Past wins reinforce the idea that to play means reward - not problems.
Leads to breaking your own values (denial, lying, cheating, etc.).

The Win

Large wins may be used to pay debts, so as to free up credit for future gambling - to stay in the game. The more times you gamble the less you value the wins or the money. Money loses its personal value over time. This can lead a person to care less about losing in the future: 'It's only free

money, it does not matter if I lose it'. Problem gamblers risk their wins by further gambling:
'If I've won this much I can win more'
'What I have won is not enough, I must try to win more'
'I feel better now, in fact I will play some more'

Chasing the Loss

When losing, feelings of panic and despair can drive a person to chase what has been lost. Not accepting losses: thinking that, if you continue, you will get your money back. It is the desire to get back what you risked to lose in the first place. Believing that after losing so much money, surely a win is close at hand. Here a person is trying to make winning more real.

More Loss

Gambling until the loss has put you into unbearable debt. Gambling until you lose all your money.

Since gambling created the loss in the first place, further gambling will create more loss.
Can lead to feelings of guilt and shame.
Can lead you to feel even worse than you did before you gambled

Financial Crisis

Being in further debt.
Financial threats: Legal action, Loss of home and/or property, No food, No rent money, Debt collectors, etc.
Financial crisis always carries with it some form of emotional crisis.

Emotional Crisis

Initial feelings of disappointment and dejection - dashed hopes, or 'as if' let down.
Great sense of remorse and feelings of helplessness and hopelessness.
Broken promises to self and others that it will not happen again - guilt and shame.

Damage to self-esteem creates a need for a coping strategy - escaping the crisis by gambling (relapse).

Greed

Not accepting past losses. Believing that you are entitled to win more.
To give - in the hope of getting more back.
Acting on the hope that you are due for a bigger win.

Apprehension

Apprehension implies an immediate state of mind produced by having good grounds for fear.

Suspicion or fear, especially of future catastrophe.
Decreasing enjoyment with increasing sufferance.
False Hope: 'My turn is near'
Pretentious: 'Surely I am worthy'

Dread

Dread is the intense reluctance to face a situation and suggests aversion as well as anxiety.

Disappointment and despair.

Becoming fearful of immediate future.

'I can't bear the idea that I'm going to lose the lot'
'I dread the outcome if I don't win'
'How could I have let myself lose so much'?
'I stuffed-up again - I'm a hopeless gambler

Information on hnadout taken from http://www.nrgs.org.au/cms/selfdiagnosis/thecycle/15

Appendix Y

Warning Signs Handout

MY LIST OF WARNING SIGNS

The following self-help intervention will help you to be more aware of yourself. The aim is: "To recognize and list my Warning Signs that may lead me to gamble".

A good way to find these indicators is to specifically think of people, places, things, situations, and attitudes in your personal life.

After writing out your list, keep it handy as a reminder.

The following list will help you to identify your warning signs.

PEOPLE

1. People I have liked gambling with (eg. fellow punters).
2. People who inspire me to gamble (eg. high stake gamblers).
3. People who will loan me money/credit for gambling (eg. a venue provider).
4. People I wish to avoid (eg. debt collectors).
5. People I have liked conversing with - about gambling (eg. an acquaintance).
6. People who may undermine my recovery efforts (eg. boasters of past wins).

PLACES

1. Places where I like to gamble (eg. favourite gambling venues).
2. Other places I like going to that also provide access to gambling (eg. internet).
3. Places that inspire me to gamble (eg. venues that televise gambling events).
4. Places that will loan me money/credit to gamble with (eg. club ATMs).
5. Places that may undermine my recovery efforts (eg, drinking venues).

THINGS

1. Personal things/items that remind me of gambling (eg. dice keyring).
2. Things that inspire me to gamble (eg. games that involve chance).
3. Things that undermine my recovery efforts (eg. gambling literature).
4. Things that trigger the urge to gamble (eg. alcohol).
5. Things that provide access to money/credit for gambling (eg. credit cards).

SITUATIONS

1. Situations I wish to avoid (eg. working for money to pay debts).
2. Situations or times when I have access to money/credit (eg. pay days).
3. Situations that inspire me to gamble (eg. listening to gambling).
4. Situations that trigger the urge to gamble (eg. considered omens).
5. Situations I may create for myself to gamble (eg. false appointments).
6. Situations that may undermine my recovery efforts (eg, poor budgeting).

ATTITUDES

1. Attitudes I wish to avoid (eg. being responsible for my recovery).
2. Attitudes that inspire me to gamble (eg. to win means success).
3. Attitudes that trigger the urge to gamble (eg. I have to win).
4. Attitudes I may create for myself to gamble (eg. resenting a support group).
5. Attitudes that may undermine my recovery efforts (eg. 'I can do it alone')

• Work out which warning signs are more likely to put you at risk than others. You can easily do this by estimating, and recording, a score out of ten (a degree of risk) for each warning sign. Example: 0 = minimal risk, and 10 = maximum risk.

Use the following list to pencil in your warning signs, and your plans to reduce those risks.

Example (places): Warning sign: *Driving past my favourite gambling venue.*
My plan to reduce the risk: *Drive an alternative route (detour).*

MY LIST OF WARNING SIGNS Date __/__/____

0 10
Warning sign:
My plan to reduce the risk -

0 10
Warning sign:
My plan to reduce the risk -

0 10
Warning sign:
My plan to reduce the risk -

0 10
Warning sign:
My plan to reduce the risk -

0 10
Warning sign:
My plan to reduce the risk -

0 10
Warning sign:
My plan to reduce the risk -

0 10
Warning sign:
My plan to reduce the risk -

0 10
Warning sign:
My plan to reduce the risk -

0 10
Warning sign:
My plan to reduce the risk -

Information on Worksheet comes from http://www.nrgs.org.au/cms/worksheets/1

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